

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>01974</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>01963</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>													
1. DECEASED-NAME (Type or print) <b>Jane</b>				First <b>E.</b> Middle <b>ADAMS</b> Last				2a. DATE OF DEATH <b>Feb. Month 10 Day 1968</b>				2b. HOUR <b>12:30 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>11-7-82</b>				6. AGE (In years lost birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. America</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel County</b> Md.							
10. CITY OR TOWN OF DEATH <b>Glen Burnie, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1520 Ingalls Road</b>					
14. FATHER'S NAME First <b>Michael</b> Middle <b>Norton</b> Last				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Constantine</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Pa. Louis C. Adams, 4361 N. 6th Street, Harrisburg</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetic coma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Fracture left hip.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>							
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>2/9 68</b> City or Town <b>2/10 68</b> County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>2/9 1968</b> , to <b>2/10 1968</b> , that (I) (we) last saw the deceased alive on <b>2/10 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Max C Frank MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/10/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>MAX C FRANK MD</b>		22e. ADDRESS <b>425 SE Ritchie Hwy Glen Burnie Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>13 Feb. 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shoops Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dauphin County, Pennsylvania</b>							
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <b>JAMES</b>			Middle <b>ANTHONY</b>			Last <b>ADDISON</b>			2a. DATE OF DEATH <b>FEB</b> Month <b>26</b> Day <b>68</b> Year			2b. HOUR <b>1130AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>NEGROID</b>			5. DATE OF BIRTH <b>8-25-1913</b>			6. AGE (In years last birthday) <b>54</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ANNE ARUNDEL</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Checker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Naval Acdm</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>A.A.Co</b>			13c. CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>208 Clay St Annapolis</b>					
14. FATHER'S NAME First <b>Frank</b>			Middle <b>NMN</b>			Last <b>Addison</b>			15. MOTHER'S MAIDEN NAME First <b>Cecelia</b>			Middle <b>NMN</b>			Last <b>Travis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>			(If yes give war or dates of service) <b>WWII</b>			16b. SOCIAL SECURITY NO. <b>212-16-0466</b>			17. INFORMANT <b>Harold N. Murray</b>			Address <b>208 Clay St Anna, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2608</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>26 FEB</b> , 19 <b>68</b> , to <b>26 FEB</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>26 FEB</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>A. C. J. Brickel</b>												22c. DATE SIGNED <b>26 FEB 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>A. C. J. BRICKEL, LT MC USNR</b>						22e. ADDRESS <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>3-1-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>PineLawn Mem.Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A.Co Md</b>								
24. FUNERAL DIRECTOR <b>Hicks Funeral Home</b>						ADDRESS <b>ANNAPOLIS, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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VR A15 (4)  
30M REV. 7-68

01976				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01965			
1. DECEASED-NAME (Type or print) First Middle Last <b>Edward Stewart BARNETT</b>				2a. DATE OF DEATH Month Day Year <b>February 14 68</b>				2b. HOUR <b>12:10 PM</b>			
3. SEX <b>male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>8.5.1905</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel Md.</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>A.A. General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>College teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>anna.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>College Terrace</b>			
14. FATHER'S NAME First Middle Last <b>James Barnett</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Eleanor Woods</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. <b>220036929</b>		17. INFORMANT Address <b>Emma C. Barnett, Annapolis Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4339</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>332x</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <b>hospital</b> attended the deceased from <b>Sept</b> , 1959, to <b>Feb</b> , 1968, that (I) <b>(we)</b> last saw the deceased alive on <b>2/13</b> , 1968, and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I) (we)</b> (did) (did not) view the body after death.											
22b. SIGNATURE <b>John L. Hedeman M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>John L. Hedeman, M.D.</b>				22c. DATE SIGNED <b>2/15/68</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2.17.1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis Md.</b>					
24. FUNERAL DIRECTOR <b>William Reese</b>				ADDRESS <b>Annapolis Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FEB 16 1953

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, 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01977										01966									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH									
ETHEL L. BECKER										February 11 1968 7304 M									
3. SEX										4. RACE									
Female										White									
5. DATE OF BIRTH										6. AGE (In years last birthday)									
Sept. 28, 1887										80 YRS.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?									
Balto., Md.										U.S.A.									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH									
										Anne Arundel Md.									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)									
Glen Burnie										No. Arundel Conv. Center									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY									
Retired										House Work									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY									
Md.										Anne Arundel									
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last									
Walter Hevern										Susan Cook									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.									
NO										NONE									
17. INFORMANT										Address									
Walter Becker										RT. 6 Box 487 PASADENA MD. 21122									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a)										Bronchopneumonia									
4129										3 wks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Arteriosclerotic heart disease 5 yrs									
										(c) Arteriosclerotic heart disease 5 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
4200																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY									
										HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)									
21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 11/11, 1966, to 2/11, 1968, that (I) (we) last saw the deceased alive on 2/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										22c. DATE SIGNED									
JOSEPH TAHER										2/12/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS									
										95 Aquahart Rd., Glen Burnie, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE									
Burial										2-14-68.									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Glen Haven Mem. Cem.										Ritchie Hwy A.A. Md.									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR									
Charles S. Guler 901 S. Conowingo St. Balto., 21224, Md.										DATE FEB 15 1968									
										25b. REGISTRAR'S SIGNATURE									
										Charles Judge									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

198 Items 18, 21 & 22 film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01967										
1. DECEASED-NAME (Type or Print)			First		Middle		Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month		Day		Year		2b. HOUR	
Harry			J.		BENZING						2		24		19		68		4:40	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		IF UNDER 24 HRS. HOURS		IF UNDER 24 HRS. MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male		white		7/23/1923		19 YRS										Month Feb. Day 24 Year 1968			4:40	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH								
Philadelphia, Pa.												Anne Arundel Md.								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY								
Millersville				Oak Circle				None												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to STATE)				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET AND NUMBER								
Bump Road Pa. 196				Montgomery Co., Pa.				Wales Road YES <input type="checkbox"/> NO <input type="checkbox"/>				North Wales Road								
14. FATHER'S NAME			First		Middle		Last			15. MOTHER'S MAIDEN NAME			First		Middle		Last			
Harry			J.		Benzing, Sr.					Sarah			Scowcroft							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS								
Yes				World War II				None				Mr. Louis C. Beck				340 Hardman Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to freezing temperature after fall DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?												
901X								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)												
								Subject fell off log while crossing stream												
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State												
				Stream (woods)				Millersville A. A Md												
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE				Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED								
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				Feb. 25, 1968								
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
								ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)								
Burial				2/28/1968				Laurel Hill Cemetery				Gwynwd, Mont. Co., Pa.								
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE								
Wm. F. Tichner + Sons				Baltimore				FEB 29 1968				[Signature]								



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

01979		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01968	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a.m. p.m.
ALBERT		J.		BERTRAM, Jr.	Feb 6 1968		10:10 a.m.
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct 25, 1911		6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Ft Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Serviceman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER Box 163, Odenton, Md	
14. FATHER'S NAME First Middle Last Albert J. Bertram, Sr.		15. MOTHER'S MAIDEN NAME First Middle Last Martha Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO. 1939 - 1961 579-34-5550		17. INFORMANT Address Sofie Bertram (W) Box 163, Odenton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 582X IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Chronic Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 592X							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 4 Jan, 1968, to 6 Feb, 1968, that (I) (we) last saw the deceased alive on 6 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Murray Corbin MD		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 Feb 1968			
22d. PHYSICIAN'S NAME (Type) MURRAY CORBIN, CPT, MC		22e. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Jesse Funeral Home		ADDRESS 2847 Wilson Blvd Arlington, Va.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE J. Corbin	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <sup>First</sup> <i>Norris</i> <sup>Middle</sup> <i>G.</i> <sup>Last</sup> <i>Booker</i>					2a. DATE OF DEATH <sup>Month</sup> <i>Feb.</i> <sup>Day</sup> <i>19</i> <sup>Year</sup> <i>1968</i>		2b. HOUR <i>3:46 PM</i>		
3. SEX <i>m</i>		4. RACE <i>w</i>		5. DATE OF BIRTH <i>5/26/1910</i>		6. AGE (In years last birthday) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>A. A.</i>		13c. CITY OR TOWN <i>Pt. Pleasant</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 235 Rt. 2 Curtis Avenue</i>	
14. FATHER'S NAME <sup>First</sup> <i>George</i> <sup>Middle</sup> <i>?</i> <sup>Last</sup> <i>Booker</i>				15. MOTHER'S MAIDEN NAME <sup>First</sup> <i>Wilamina</i> <sup>Middle</sup> <i>?</i> <sup>Last</sup> <i>Grund</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No.</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>215-09-8820</i>		17. INFORMANT Address <i>Gertrude Booker As Above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Undifferentiated bronchogenic carcinoma with generalized metastases.</i> DUE TO, OR AS A CONSEQUENCE OF <i>metastases.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>bronchopneumonia.</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 19 <i>67</i> , to <i>Feb. 19</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. A. de Guzman M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>2/19/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>B. A. de Guzman M.D.</i>				22e. ADDRESS <i>325 HOSPITAL DR. GLEN BURNIE, Md. 21061</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/23/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Brooklyn, Maryland</i>			
24. FUNERAL DIRECTOR <i>Raymond C. Fink</i> ADDRESS <i>Glen Burnie, Md.</i>				25a. REC'D BY REGISTRAR <i>FEB 21 1968</i> DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01981

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01970

1. DECEASED-NAME (Type or Print) First Middle Last JOSEPH EDGAR BRUBAKER, SR.			2a. DATE KNOWN OF DEATH Month Day Year 2 15 68			2b. HOUR A M A			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 12, 1915	6. AGE (in years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Feb. 15 1968			
7a. BIRTHPLACE (State or foreign country) Pennsy.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL OR INSTITUTION (If not in home give street address) # 409 BALTO. / ANNAP. BLVD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY SPRING CORP.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 409 BALTO. / ANNAP. BLVD., N/E	
14. FATHER'S NAME First Middle Last (unknown) BRUBAKER			15. MOTHER'S MAIDEN NAME First Middle Last EDNA (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) U.U. 11		17. INFORMANT ADDRESS Mr. Joseph Brubaker (son) Altoona, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2/15 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Self inflicted</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. <u>409 Buelo Annapolis Blvd</u>		City or Town <u>MD</u>		County <u>MD</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> <del>Homicide</del> <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>F. Linhaert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <u>2/15/68</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>R.L. Singleton</u>				ADDRESS <u>Singleton Funeral Home/Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01982 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01971							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR					
IRVIN			Bernard		Butler					Month Day Year		A M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
M		W		12-28-23		44 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year		A M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.					
Maryland			U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			A-A-CU								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Glen Burnie			DEX-Mark Arnold			Welder Mechanic			Westinghouse								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Maryland			Anne Arundel			Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			920 Roseanne Road			21061		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
Thomas E. Butler Sr.									Estelle Wiflint								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
Yes			W W 11			Mrs. Billie Butler			920 Roseanne Road			21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot wound Skull</u> 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Smith</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 976X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
CAUSE OF DEATH			HOUR A.M. P.M.			21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			2/5 19 68			Self inflicted gun shot wound			MDCO			MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED							
ACTUAL SIGNATURE			E. L. Hubbard			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER					
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			2/7/68			Glen Haven Memorial Park			Glen Burnie A. A. Co. Md.								
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
McCully Funeral Home			237 Patapsco Ave 21225			FEB 7 1968			John Charles Judge								

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EXAMINATION OF THE

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U. S. A.

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James T. Fisher, Jr. 1910

James T. Fisher, Jr.

1910

James T. Fisher, Jr. 1910

James T. Fisher, Jr. 1910

James T. Fisher, Jr. 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
01983		01972								
1. DECEASED-NAME (Type or print) <b>Josephine</b>			First <b>Josephine</b>			Middle <b>Capretti</b>			Last <b>Capretti</b>	
3. SEX <b>Female</b>			4. RACE <b>Cauc.</b>			5. DATE OF BIRTH <b>22 March 1896</b>			6a. DATE OF DEATH <b>Feb. Month 25 Day 1968</b>	
6. AGE (In years lost birthday) <b>71</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			2b. HOUR <b>8:55</b> M <b>M</b>	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>			7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b>	
10. CITY OR TOWN OF DEATH <b>Pasadena</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>19 Magothy Bridge Rd</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOME</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Pasadena</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>19 Magothy Bridge Rd.</b>			14. FATHER'S NAME First <b>UNK</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>UNK</b> Middle <b></b> Last <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO. <b></b>			17. INFORMANT <b>N. ARUNDEL Hospt. GHEU BURVIE, MD.</b>			Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure &amp; Renal Failure</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ca of Artery - Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1750</b>										
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>				
22a. I certify that (I) (this hospital) attended the deceased from <b></b> , 19 <b></b> , to <b></b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>2-25-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Carlos E. Arrabal</b>			DEGREE <b></b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-25-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Carlos E. Arrabal</b>			22e. ADDRESS <b>2705 Mountain Rd. Pasadena, Md. 21122</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2-29-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony</b>			23d. LOCATION (City or Town) (County) (State) <b>RICHARDTOWNSHIP Pa.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor</b>			ADDRESS <b>5400 Annapolis, Md.</b>			25a. REC'D BY REGISTRAR <b>FEB 28 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
01984					01973					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last CORLESS BYRD CARTER					FEB Month 14 Day 1968 Year			3:30a.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Negro		Jun 29, 1929			37 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Newahitchka, Fla		USA				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Ft Geo G Meade, Md		Kimbrough Army Hosp			Housewife			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Anne Arundel		Ft Meade				8007-C Traynor Court		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last William Byrd			First Middle Last Johnnie Mae Land							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No -		263-34-4331		Andrew J. Carter (same as item # 13)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laennec's Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ascites</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days Unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5811										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
None										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 26 Jan, 19 68, to 14 Feb, 19 68, that (I) (we) last saw the deceased alive on 14 Feb 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph A Rhyme</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 14 Feb 68		
22d. PHYSICIAN'S NAME (Type) JOSEPH A. RHYNE, III, CPT, MC								22e. ADDRESS KIMBROUGH ARMY HOSP, FT MEADE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		2-19-68		Arlington Natl		Arlington Va.				
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Watson Funeral Inc		3455-14 Mt. N.E.		14 FEB 20 1968		John B. J. J.				

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(Continued on page 2)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01985		01974							
1. DECEASED-NAME (Type or print) <b>Ann Elizabeth CAULK</b>			First Middle Last			2a. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>A.</b> <b>10:15</b>
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov 12 1889</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>AA General Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NURSING</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>729 Rosedale St</b>	
14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>EVANS</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>155-03-3471</b>		17. INFORMANT Address <b>Evelyn C Wood 729 Rosedale St. Annapolis</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unknown</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201 Bronchial asthma</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , to <b>2/22</b> , 1968, that (I) (we) last saw the deceased alive on <b>2/22</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard I. Hochman, MD</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/23/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>					22e. ADDRESS <b>16 Murray Ave., Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>2-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Prince Geo. Md</b>			
24. FUNERAL DIRECTOR <b>TA Hordesty</b>		ADDRESS <b>12 Ridgely Ave. Annapolis, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Yung</b>			

47210

MINISTRY OF DEFENSE

08210

1. NAME OF THE PARTY OR PERSON: [illegible]

2. ADDRESS: [illegible]

3. DATE OF BIRTH: [illegible]

4. PLACE OF BIRTH: [illegible]

5. OCCUPATION: [illegible]

6. EDUCATION: [illegible]

7. MARITAL STATUS: [illegible]

8. NUMBER OF CHILDREN: [illegible]

9. RELIGION: [illegible]

10. POLITICAL AFFILIATION: [illegible]

11. SOCIAL SECURITY NUMBER: [illegible]

12. SIGNATURE: [illegible]

13. DATE: [illegible]

14. OFFICIAL SEAL: [illegible]

15. COMMENTS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

01986				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01975				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR A M	
Connie Ellen CHAMBERS							February 1 1968				11:40	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 24, 1904			6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First Middle Last Porter Doll			15. MOTHER'S MAIDEN NAME First Middle Last Sally l.n. unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Herbert Chambers - same as #13 above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction; Complete M.I. dissec. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Approximate interval between onset and death 410.9 48 hours 48 hours years.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus for 17 years; Exog. Obesity												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from July 1966, to Feb 1, 1968, that (I) (we) last saw the deceased alive on Feb 1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.												
22b. SIGNATURE Peter F. Verkouw				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1-Febr. 68.				
22d. PHYSICIAN'S NAME (Type) Peter F. Verkouw, M.D.				22e. ADDRESS 1407 Forest Drive, Annapolis, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/3/68		23c. NAME OF CEMETERY OR CREMATORY Wells View Cemetery			23d. LOCATION (City or Town) (County) (State) Weems Creek A.A. Md.					
24. FUNERAL DIRECTOR Hopping Funeral Home - Annapolis, Md.				25a. REC'D BY REGISTRAR DATE FEB 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

73210

27010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01987		01976							
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH			2b. HOUR
Clara R Childress						Month Day Year			10:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		11/18/85			82 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		United States				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Crownsville			Crownsville State Hos P.			Domestic			Domestic
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore		Baltimore				849 McKIN STREET
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			217-03-8598		Crownsville State Hospital Records Crownsville, Maryland 21032				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X Vaso motor Collapse									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary Asphyxia									3 days
DUE TO, OR AS A CONSEQUENCE OF (c) Viral pneumonia									1 WK.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 492X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1/18, 19 68, to 2/22, 19 68, that (I) (we) last saw the deceased alive on 2/22, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Daughtery MD						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/22/68	
22d. PHYSICIAN'S NAME (Type) John H. Daughtery M.D.						22e. ADDRESS Crownsville State Hospital Crownsville, Maryland 21032			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 24, 1968		Thornrose Cemetery,		Staunton, Virginia 24401			
24. FUNERAL DIRECTOR John M. Lyford Son Annapolis Md.						25a. REC'D BY REGISTRAR DATE FEB 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

01981

CERTIFICATE OF DEATH

01981

State of New York

County of New York

1981

1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01988

01977

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michelle</b> Middle <b>Clark</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 68</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-57</b>
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calvin Clyde Clark</b>		14. MOTHER'S MAIDEN NAME <b>Delores Green</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Children's Center Hospital, Laurel, Md.</b>		Address <b>-----</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infection</b> <b>5199</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>5272</b> (b) <b>-----</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>mild dehydration; Mental retardation (Severe)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 6</b> , 19 <b>58</b> , to <b>Feb. 18</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb. 18</b> , 19 <b>68</b> , and that death occurred at <b>1:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Loretta K. Gilmore</b> M.D.		22b. DATE SIGNED <b>2-19-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>LORETTA K. GILMORE, M. D.</b>		22d. ADDRESS <b>Children's Center Hospital, Laurel, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-23-68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>R. Lewis Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE B 23 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		25c. REGISTRAR'S SIGNATURE	

01977

01984

01984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>ETHEL</b> First Middle Last <b>CORBIN</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>5:30A</b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-29-1902</b>			6. AGE (In years last birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>650 AMERICANA DR. HOUSEWIFE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life (even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>650 AMERICANA DR</b>		
14. FATHER'S NAME First Middle Last <b>HERMAN GUTTMAN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>"UNK"</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>WILL H. CORBIN #13E</b>			Address <b>#13E</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion?</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4101</b> (b) <b>Coronary Artery Disease 2 ty</b> <b>4101</b> DUE TO, OR AS A CONSEQUENCE OF <b>Congestive Heart Failure 2 ty</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Dichloride</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>2-28-1968</b> , that (I) (we) last saw the deceased alive on <b>2-29-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Franklin Stipley MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>2-29-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>FRANKLIN STIPLEY</b>						22e. ADDRESS <b>Annapolis</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG MD.</b>					
24. FUNERAL DIRECTOR <b>John M. Saylor</b> ADDRESS <b>Annapolis Md.</b>						25a. REC'D BY REGISTRAR <b>MAK</b> DATE <b>4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Franklin Stipley</b>			

48010

4212 JG

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01990 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01979				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or Print)			First		Middle		Last			2a. DATE KNOWN <input type="checkbox"/> Month Day Year		2b. HOUR OF ESTI- DEATH MATED <input type="checkbox"/> 2 15 1968 A M		
IVA			McCAULEY		COULTER (BRUBAKER)									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR		
FEMALE		WHITE		SEPT. 6, 1920		47 YRS.				FEB. 19		19 68 P M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
			U.S.A.						ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE			#409 BALTO/ANNAP.BLVD., N/E											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
MARYLAND			ANNE ARUNDEL			GLEN BURNIE						409 BALTO./ANNAP.BLVD., N/E		
14. FATHER'S NAME			First		Middle		Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
George			A.		McCauley					Margaret (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS			344 Main St.		
no			UNKNOWN			Herbert P. Coulter, Jr.			Bellwood, Pa.			16617		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gun shot wounds skull</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2/15 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>gun shot wound skull</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>409 Bellwood Blvd MD</i>								
22o. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>E. H. W. Barker</i>			EXAMINER'S NAME (Type) <i>E. H. W. Barker</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <i>2/15/68</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			2/19/68		Glen Haven Memorial Pk.			Glen Burnie, Maryland						
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
R.V. Songleton / Glen Burnie, Maryland									DATE FEB 19 1968			<i>Charles J. Jones</i>		

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STATE OF NEW YORK

IN SENATE

January 10, 1900

REPORT

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01991

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01980

1. DECEASED-NAME (Type or Print) <b>Elmer E Cross</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>2</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>8 P</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>11-1-11</b>	6. AGE (in years last birthday) <b>56</b> YRS.	7c. DATE PRONOUNCED DEAD Month <b>2</b> Day <b>27</b> Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA-NORTH ARUNDEL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Clerk</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <b>Emmett</b> Middle <b>Rufus</b> Last <b>Cross</b>		15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>E.</b> Last <b>Johnson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>236-14-6179</b>	17. INFORMANT ADDRESS <b>21061 Mr. Dale Cross, 1633 Tieman Drive, Glen Burnie</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis generalized</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4500</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>E. Linhardt</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/27/68</b> <b>HACO.</b>
EXAMINER'S NAME (Type) <b>E. Linhardt</b>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3-2-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Thomas, West Virginia, Tucker County</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		24b. ADDRESS <b>21229</b>	25a. REC'D BY REGISTRAR <b>MAR 4 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>

05/20/2000

14216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01992

01981

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN TB <u>2 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. - Rosedale</u>		d. STREET ADDRESS <u>1319 Roxboro Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Conv. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ollie Elizabeth Curlee</u>		4. DATE OF DEATH <u>2</u> Month <u>6</u> Day <u>19</u> Year <u>68</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/87</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Cartin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Jumper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT (Son) <u>Mr. William Curlee, 3416 Dunhaven Rd.</u>		Address <u>Dundalk, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> DUE TO (b) <u>Metastatic disease (Generalized)</u> DUE TO (c) <u>Cancer of the breast (a)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>170X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> , 19 <u>67</u> , to <u>2-6-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-5-</u> , 19 <u>68</u> , and that death occurred at <u>4:10 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Orlando E. Ramos</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/6/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Orlando E. Ramos MD</u>		22d. ADDRESS <u>Arundel Medical Group</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/9/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marshville City Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Marshville Union N.C.</u>
24. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1968</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01281

EXHIBIT OF DEED

01282

Bellevue

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR 2:10 <sup>PM</sup>
Albert		Floyd		Denner		Feb 12 1968					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-25-94			6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.					
10. CITY OR TOWN OF DEATH Glen Burnie, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 66 Lake Shore, Swift Md.			
14. FATHER'S NAME First Middle Last Charles Denner				15. MOTHER'S MAIDEN NAME First Middle Last Frances Beck Denner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 214-44-2856		17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Left Ventricular Failure</u> 395.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Valve Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4211											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-10-1968 to 2-12-1968, that (I) (we) last saw the deceased alive on 2-12-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Helary M. [Signature]</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 2-12-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-15-1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

588 FG

2226

For the Vice President

2

5-15-58 11-01-58 5-10-58 5-15-58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01994

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01983

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>G. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>		d. STREET ADDRESS <u>Old Harbor Harbor Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Blenda Ann Wiggs</u>		4. DATE OF DEATH <u>2-29-68</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1947</u>
9. AGE (In years last birthday) <u>20</u>		10. IF UNDER 1 YEAR <u>2</u> Months <u>20</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Wiggs</u>		14. MOTHER'S MAIDEN NAME <u>Anna Griffin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Anna Wiggs</u>		Address <u>Crownsville MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>465X</u> IMMEDIATE CAUSE (a) <u>Acute upper respiratory disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Due to</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>475X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>2-29-68</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-4-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	23d. LOCATION (City or Town) (County) (State) <u>Waterbury MD</u>
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 4 1968</u>	
		25b. REGISTRAR'S SIGNATURE	

88010

88010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01995</div> <div> <div>01984</div> <div>01984</div> </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
George Watkins DOLAN						February 5 1968		12:45			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		W		6-8-1887		80					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
N.Y.		U.S.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis				H.A. GENERAL				WELDER		U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.				A.A.		Annapolis				131 RIVERVIEW AVE.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Joseph E. DOLAN				Laura Blordeu							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
				216 126118		Mary Anna Dolan #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus c gen. metastasis										2 mos.	
150X											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
150X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Apr. 53, 19, to Feb. 5, 1968, that (I) (we) last saw the deceased alive on Feb. 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
S. Borssuck, M.D.						2/5/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
S. Borssuck, M.D.						Amos Garrett Blvd., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State	
BURIAL		2-7-68		CEDAR HILL		Brooklyn		A.A.		MD.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Lofthouse Annapolis, Md.						DATE FEB 7 1968		[Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>01996</p> <p>Items 13c &amp; e Film G398 2/28/68</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>01985</p> </div> </div>											
1. DECEASED-NAME (Type or print) <b>Harrison</b>						2a. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1968</b>		2b. HOUR <b>6:30</b> AM			
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>4-24-1918</b>		6. AGE (In years last birthday) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>12</b>		IF UNDER 24 HRS. HOURS <b>6</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>A. A. General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Self</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Wood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Community of Cumberstone</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>Donner</b> Last <b>Donner</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Brent</b> Last <b>Brent</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>5900</b>		17. INFORMANT <b>George Donner Cumberstone</b> Address <b>Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic Pylopharyngeal anemia</b> <b>5900</b> DUE TO, OR AS A CONSEQUENCE OF <b>chronic Pylopharyngeal anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>10 mos</b> (b) <b>10 mos</b> DUE TO, OR AS A CONSEQUENCE OF <b>10 mos</b> (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>6000</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>fall</b>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. T. Allen</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>2-20-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>W. T. ALLEN</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Owensville Md.</b>					
24. FUNERAL DIRECTOR <b>William Reese</b>		ADDRESS <b>Annapolis Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1910

TO THE SECRETARY, UNITED STATES DEPARTMENT OF AGRICULTURE

21

WASHINGTON, D. C.



21

RECEIVED

1910

WASHINGTON, D. C.

Very respectfully,  
[Signature]



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>William G. Eddinger</i>					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>18</i> Year <i>1968</i>					2b. HOUR <i>P</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>5/3/1915</i>		6. AGE (In years last birthday) <i>52</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>		2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>18</i> Year <i>1968</i>	2d. HOUR <i>P</i>	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>443 Fourth St.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Doit Building</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. CITY OR TOWN <i>Anne Arundel</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>443 Fourth St.</i>			
14. FATHER'S NAME First <i>Everett</i> Middle <i>Eddinger</i> Last <i></i>					15. MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Byerly</i> Last <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Margaret Eddinger</i>			ADDRESS <i>Thomasville, N.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>subarachnoid hemorrhage</i>										<i>acute</i>	
4409 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>4-20-68</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i></i>			21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i>		State <i></i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. L. Linhardt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED <i>2/18/68</i>	
EXAMINER'S NAME (Type) <i>E. L. Linhardt</i>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (Street, city, town, or county) <i>SAAC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>2-21-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rich Fork Baptist Cemetery</i>		23d. LOCATION (City or Town) <i>Davidson Co.</i>		(County) <i>NC</i>		(State) <i>NC</i>	
24. FUNERAL DIRECTOR <i>John M. Taylor &amp; Sons</i>					ADDRESS <i>Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>		
					DATE <i>FEB 21 1968</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> 01998  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  Item 6 Film G398 3/6/68 ap  <b>CERTIFICATE OF DEATH</b>  01987 </div>											
1. DECEASED-NAME (Type or print) <b>Richard Elm</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>8:45p</b> M		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>5/28/04</b>			6. AGE (In years last birthday) <b>67 64</b> YRS.		IF UNDER 1 YEAR MONTHS <b>68</b> DAYS <b>64</b>		IF UNDER 24 HRS. HOURS <b>68</b> MIN. <b>45</b>
7a. BIRTHPLACE (State or foreign country) <b>Unknown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Crownsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Crownsville State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unknown</b>			12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Unknown</b>			13b. COUNTY <b>Unknown</b>		13c. CITY OR TOWN <b>Unknown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Unknown</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records, Crownsville State Hosp., Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>433.7</b> DUE TO, OR AS A CONSEQUENCE OF (c) ----- PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome; lues</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from <b>6/2</b> , 19 <b>55</b> , to <b>2/3</b> , 19 <b>68</b> , that (we) lost saw the deceased alive on <b>2/3</b> , 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>L. Benedict</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/6/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>						22e. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>FEB. 28 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>V. of Md. MED. SCHOOL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md.</b>					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
John			Frederick ENGELMANN			February 23, 1968			11:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		May 3, 1884			83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Germany		U.S.A.				Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			A. A. Co. Gen. Hospital			Home Builder (Ret.)			Self-Empol.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis				111 Bay View Dr. Hillsmere	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Arnold Engelmann			(Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
None			213-18-1722		Mrs. A. Irene Engelmann (wife) Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)								3 weeks unfamiliar		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
332 X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1964, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Richard I. Hochman, M.D.					2/25/68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Richard I. Hochman, M.D.					16 Murray Ave, Annapolis, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Feb. 27, 1968		Cedar Hill Cemetery		Brooklyn B F D Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
E. B. Fleming					DATE FEB 27 1968		Charles Judge			
Singleton Funeral Home					Glen Burnie, Md.					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02000 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7a Film G398 2/18/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01989

1. DECEASED-NAME (Type or Print) First Middle Last DEBRA KAY ERGOTT			2a. DATE KNOWN OF DEATH Month Day Year 2 13 1968			2b. HOUR 3:00 P.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 6-30-67	6. AGE (in years last birthday) 7 YRS 7 MONTHS 7 DAYS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year February 13 1968			2d. HOUR 3:00 P.
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Fort Meade (Laurel)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A. A. County		13c. CITY OR TOWN Fort Meade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Forrest Ave.
14. FATHER'S NAME First Middle Last WILLIAM R. ERGOTT			15. MOTHER'S MAIDEN NAME First Middle Last MARY ANN SWINEHART					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 525X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Edward F. Wilson</i> EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			22b. DATE SIGNED February 14, 1968		
			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		

23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE February 17 1968		23c. NAME OF CEMETERY OR CREMATORY Woodrich Cemetery		23d. LOCATION (City or Town) (County) (State) Chen Town Co. Penn.	
24. FUNERAL DIRECTOR <i>Laurel Funeral Home</i> ADDRESS Laurel Md.				25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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01882

FILE 18-208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
WILLIAM			M.		ERMINE				Month	Day	
									2	3	
									Year	2b. HOUR	
									1968	10:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
Male		White		May 18, 1900			67		MONTHS		
									DAYS		
									HOURS		
									MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville St. Hosp			Machine Shop			Bethlehem Steel Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland						BALTIMORE				5629 Greenhill Ave.	
14. DECEASED'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle								
Thomas -			ERMINE			Mary -			Glasser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If not, give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Wife)			Address		
Yes, no, or unknown			071-05-684			Mrs. Betty A. Ermine			Balto. Md.		
									5629 Greenhill Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) PULMONARY TBC.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
0021											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town		
While <input type="checkbox"/> Not while <input type="checkbox"/>						Street or R.F.D. No.			County		
at work <input type="checkbox"/> at work <input type="checkbox"/>									State		
22a. I certify that (X) (this hospital) attended the deceased from 4/1/68, 19, to 2/3/68, 19, that (I) (we) last saw the deceased alive on 4/3/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
L. BENEDICT M. J.											
22c. DATE SIGNED											
2/3/68											
22d. PHYSICIAN'S NAME (Type)											
Crownsville State Hospital											
23a. BURIAL, CREMATION, REINTERMENT (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/6/68		Mount Carmel Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Duda, 7922 Wise Ave. Dundalk, Md.						DATE FEB 7 1968		Charles J. J.			

112210

071-02-023. KENNEDY, EUGENE, JR. DUNSTON, W. MAY 1941 - 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02002 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 13e Film G398 2/29/68 kk												01991			
1. DECEASED-NAME (Type or print) <b>Amanda Louise ESTILL</b>						2a. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1968</b>				2b. HOUR <b>8<sup>00</sup> A</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 15, 1884</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>					
7a. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.									
10. CITY OR TOWN OF DEATH <b>MILLERSVILLE, MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>KNOLL WOOD NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NURSE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Millersville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. <b>2</b> Box <b>66</b> <b>MILLERSVILLE, MD.</b>						
14. FATHER'S NAME First <b>Not Known</b> Middle <b></b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Agnes</b> Middle <b>Cornelia</b> Last <b>Murphy</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>HOUSE JOYCE #130</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>485X</b> <u>Brachygnathus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>491X</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b> <b>Left hip fracture</b>															
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b>Mar</b> Day <b>15</b> Year <b>1966</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Patrol fell at home</b>											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <b></b>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>Rt 2 Box 66</b> City or Town <b>MILLERSVILLE</b> County <b>MD.</b> State <b></b>											
22a. I certify that (I) <b>Charles W. Kinzer</b> attended the deceased from <b>July 18, 1966</b> , to <b>Feb 12, 1968</b> , that (I) <b>we</b> last saw the deceased alive on <b>Feb 4, 1968</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> (did) (did not) view the body after death.															
22b. SIGNATURE <b>Charles W. Kinzer</b>						DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12 Feb 68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M.D.</b>						22e. ADDRESS <b>16 Murray Ave., Annapolis, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FRANKFORT</b>		23d. LOCATION (City or Town) (County) (State) <b>FRANKFORT Ky.</b>									
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis Md.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>							







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
01992														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M					
SERAFINA			FARO			February 27 68			2 P					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female		White		Nov. 11, 1889			78 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Italy			Italy						Anne Arundel Co.			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Linthicum			Hammonds Ferry Rd.			Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			A.A.Co.			Linthicum						627 N. Hammonds Ferry Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
Joseph Dell'Acqua			Maria Grancaguoho											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address								
no			NONE			Mary Stiel - 704 N/Hammonds Ferry Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro-vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>331X</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-22-68</u> to <u>2/27/68</u> , that (I) (we) last saw the deceased alive on <u>2-27-68</u> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Florian P Nadolski</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>2-28-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Florian P Nadolski</u>										22e. ADDRESS <u>2619 Hammonds Ferry Rd 21227</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
Burial		2 March 68		Holy Redeemer Cemetery		Baltimore, Maryland								
24. FUNERAL DIRECTOR <u>E.B. Flery</u> Address <u>Singleton Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02004

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01993

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Vito		William	Ferrigno	2 Month 24 Day 1968		11 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		11/11/89		78 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD	U.S.				H-S Anne Arundel M.d.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bal. MD.		Crownville - state hosp		steel worker		steel worker		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD.				Bal				203 S. East ave Bal 24
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Joseph —		Freda —		Ferrigno				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
no		213-09-105		his wife Anna Ferrigno -				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 436.9 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis, senility DUE TO, OR AS A CONSEQUENCE OF lost. 337X (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic brain syndrome, impaired hearing								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1-9-1968, to 2-24, 1968, that (I) (we) last saw the deceased alive on 2-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
L. BENEDICT M.D.		3/5/68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
L. BENEDICT M.D.		Crownville State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/28/68		Holy Redeemer		Balto. Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph M. Ferrigno		263 S. Conkling St		FEB 26 1968		Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02005		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01994			
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
ELVA		D	FETSCH	FEB	Month 18	Day	Year 68	4:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
FEMALE		WHITE		1-28-10		38 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Md.		USA		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		A. A. Co.		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		H. A. H.		Housewife		@ home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		H. A.		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27 Old Annapolis Rd	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
Charles		E.	Davis		Margaret L.		Keeling		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes, no, or unknown				Joseph M. Fetsch - Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4120		GVA		HCV					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		443X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
I have never attended deceased - checked coroner									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Robert R. Hahn						2-19-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Robert R. HAHN		Severna Park							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-21-68		Baltimore National		Baltimore City, Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert S. Saravaco		Severna Park		DATE FEB 23 1968		Charles Judge			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01995

1. DECEASED-NAME (Type or Print) First Middle Last JOE F Fowler			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 2 21 1968			2b. HOUR A M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 10-6-31	6. AGE (in years) 36 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 2 21 1968		2d. HOUR A M
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.CO. Md.	
10. CITY OR TOWN OF DEATH 99 Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dea. North ARUNDEL		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Can Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY AA CO		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Luther Frank Fowler		15. MOTHER'S MAIDEN NAME Matthe Pitt		13e. STREET AND NUMBER Box 530 A, Rt 3			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean		16b. SOCIAL SECURITY NO. 23446270		17. INFORMANT Mrs Gertrude Fowler - Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun slash wound anterior chest blade 955X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Twelve
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 976X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2/21 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Self inflicted gun slash wound			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) yard		21f. LOCATION Street or R.F.D. No. Rt 3 - Box 530 A -		City or Town County State AA CO MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. L. Linhardt		EXAMINER'S NAME (Type) E. L. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) AA CO.		22b. DATE SIGNED 2-21-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/23/68		23c. NAME OF CEMETERY OR CREMATORY Belle National		23d. LOCATION (City or Town) (County) (State) Belle AA CO MD	
24. FUNERAL DIRECTOR Robert S. Barranco		ADDRESS 2nd		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01996									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Carl B. Gallion Sr.						Feb. 23, 1968			12:44 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		1-14-01		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel Hospital			Paper Mill		Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Howard AA		Seyvern		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 114 Rt. #2
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frank B. Gallion			Mary Shipley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			212-26-8533		Mildred U. Gallion, same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute posterior coronary thrombosis with massive myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 17, 1968</u> , to <u>Feb. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>L. G. de Guzman, M.D.</u>		<u>2/23/68</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>B. A. de GUZMAN, M.D.</u>		<u>325 HOSPITAL DR. SUITE 108 GLEN BURNIE, MD. 21061</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		26 Feb. 68		Loudon Park Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR		25a. "REC'D BY REGISTRAR"		25b. REGISTRAR'S SIGNATURE					
Kirkley Funeral Home, Glen Burnie, Md.		DATE FEB 26 1968		<u>[Signature]</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02008

01997

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel County</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. LENGTH OF STAY IN lb <u>Lifetime</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		d. STREET ADDRESS <u>Box # 20 -A-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henrietta N. Gardner</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>28</u> Year <u>1968</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 2, 1879</u>	<b>9. AGE</b> (In years last birthday) <u>88</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Private Family</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Portland, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Stephen Hebron</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Tyler</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-36-0422</u>		<b>17. INFORMANT</b> <u>Mr. Frank Hebron - Box 205-A- Hanover, Md</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>4129</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infirmities of Age</u> DUE TO (c) <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept</u> <u>1967</u> , to <u>Feb 28</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>7-4-1968</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Dr B. Brumbaugh</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr B. Bruce Brumbaugh</u>				<b>22d. ADDRESS</b> <u>5609 Main Street - Elkridge, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/2/68</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Auburn Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Baltimore, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Herbert E. Nutter</u>				<b>ADDRESS</b> <u>3035 W. North Ave</u> <u>Baltimore, Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> DATE <u>MAR 4 1968</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div>02009</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01998</div>									
1. DECEASED-NAME (Type or print) <b>Harry</b> <b>J.</b> <b>Gregor</b>				2a. DATE OF DEATH <b>2</b> Month <b>5</b> Day <b>68</b> Year				2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 6, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Brooklyn</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>111 6TH Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sugar</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Brooklyn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>111 6th. Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Marre Swoboda</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 09 6450</b>		17. INFORMANT Address <b>Mrs. Mabel Lamberth 111 6th. Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Artenosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2-3 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1, 1953</b> , to <b>Feb. 5, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harry Deibel</b>				22c. DATE SIGNED <b>2/7/68</b>				22d. PHYSICIAN'S NAME (Type) <b>Dr. Harry Deibel</b>	
22e. ADDRESS <b>L226 S. Hanover Street Zone 30</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2 9 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, A. A. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Mc Cully</b>				ADDRESS <b>130 E. Fort Ave</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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01324

Name	Address	City	State	Zip
John Doe	123 Main St	New York	NY	10001
Jane Smith	456 Elm St	Los Angeles	CA	90001
Bob Johnson	789 Oak St	Chicago	IL	60601
Alice Brown	321 Pine St	Houston	TX	77001
Frank White	654 Maple St	Phoenix	AZ	85001
Grace Green	987 Cedar St	Philadelphia	PA	19101
Henry Black	147 Birch St	San Antonio	TX	78201
Ivy Gold	258 Spruce St	San Diego	CA	92101
Leo Silver	369 Willow St	Dallas	TX	75201
Mia Bronze	470 Ash St	San Jose	CA	95101
Noah Copper	581 Hickory St	Austin	TX	78701
Olivia Iron	692 Sycamore St	Jacksonville	FL	32201
Peter Lead	703 Chestnut St	Fort Worth	TX	76101
Quinn Tin	814 Walnut St	Columbus	OH	43201
Ruth Zinc	925 Elm St	Indianapolis	IN	46201
Sam Cadmium	136 Maple St	San Francisco	CA	94101
Tina Mercury	247 Oak St	Seattle	WA	98101
Victor Silver	358 Pine St	Denver	CO	80201
Wendy Gold	469 Cedar St	Portland	OR	97201
Xavier Bronze	570 Birch St	San Luis Obispo	CA	93401
Yara Copper	681 Spruce St	Nashville	TN	37201

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

02010

**CERTIFICATE OF DEATH**

01989

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>6 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convalescent Center</u>				d. STREET ADDRESS <u>8429 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daisy Gunther</u>				4. DATE OF DEATH <u>Feb 21 1968</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20, 1877</u>		9. AGE (In years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacobs</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Patricia Leonard, Rivera Beach, Md.</u> Address: <u>8429 Main Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRIMARY LUNG CARCINOMA</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1621</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1965</u> , to <u>21 FEB, 1968</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>20 FEB 1968</u> , and that death occurred at <u>8:35 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>C. Earl Hill</u>				22b. DATE SIGNED <u>21 Feb 68</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. Earl Hill</u>				22d. ADDRESS <u>395 Ft. Smallwood Rd. Pasadena Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-24-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>4101 Edmondson Avenue</u> <u>Witzke Funeral Directors, Balto., Md. 21229</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled for burial, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>4</div> <div>1</div> <div>02011</div> <div> <div>02000</div> <div>02000</div> </div>											
1. DECEASED-NAME (Type or print)								2a. DATE OF DEATH		2b. HOUR	
<div>Blanche</div> <div>Snellings</div> <div>Hanky</div>								<div>2/</div> <div>18</div> <div>Day</div> <div>Year</div>		<div>1145</div> <div>PM</div>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		3/2/01		67		MONTHS		DAYS	
						YRS.		HOURS		MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia			U.S.A.						Anne Arundel Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			North Arundel								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel			Glen Burnie				107 Second Ave., S.E.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Peter Snellings				Louise Beagle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No						Mrs. M.W. Thompson			Towson, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the breast</i> 1829 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										3-6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
178 <i>Acute myocardial infarction</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>2-1-68</i> , 19 <i>68</i> , to <i>2-18-68</i> , that (I) (we) last saw the deceased alive on <i>2-18-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Aditya M. Singh</i>						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-18-68</i>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		2-21-1968		Holy Cross		Richmond Virginia					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Charles E. Liles						Richmond, Va.		FEB 23 1968		<i>[Signature]</i>	

03280

03280

Germania's history

State Department of the

April 1914  
D  
3-18-14



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

02012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02661

1. DECEASED-NAME (Type or Print) First <u>Gordon</u> Middle <u>King</u> Last <u>Harris, Jr.</u>			2a. DATE KNOWN OF DEATH ESTIMATED Month <u>2</u> Day <u>26</u> Year <u>1968</u>			2b. HOUR <u>7</u> M	
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>12/28/49</u>	6. AGE (In years last birthday) <u>18</u> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD Month <u>2</u> Day <u>26</u> Year <u>1968</u>	
7a. BIRTHPLACE (State or foreign country) <u>North Dakota</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>D.A.CO.</u>	
10. CITY OR TOWN OF DEATH <u>Annapolis-</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>D.A. - Annapolis, Md.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Student</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince Geo</u>		13c. CITY OR TOWN <u>Forestville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>7447 Keystone Lane</u>							
14. FATHER'S NAME First <u>Gordon</u> Middle <u>K</u> Last <u>Harris</u>			15. MOTHER'S MAIDEN NAME First <u>Emily</u> Middle <u>C</u> Last <u>Callaway</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Fordon K. Harris 7447 Keystone Lane</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple injuries</u> <u>816.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>819.4</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <u>2/26 1968</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Auto struck fence object</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>2/26 1968</u> <u>P.M.</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Auto struck fence object</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rt. 4 1 mile so. Wayson's Corner AA Md.</u>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linphan St.</u>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/26/68</u> <u>A.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-29-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forestville Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> <u>4308 Suitland Rd Suitland Maryland</u>				25a. REC'D BY REGISTRAR <u>FEB 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10250

\$1089

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02013

CERTIFICATE OF DEATH

02002

1. DECEASED-NAME (Type or print) <b>VERBENA</b> First <b>H</b> Middle <b>HICKS</b> Last			2a. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>10<sup>15</sup> AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>19 Sept. 1883</b>		6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.		
10. CITY OR TOWN OF DEATH <b>Millersville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Knokwood N/Home</b>		12a. USUAL OCCUPATION (Kind of work done during mast of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>P.A. Co.</b>	13c. CITY OR TOWN <b>edenton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>1246 Brietwent Ave.</b>	
14. FATHER'S NAME First <b>W. Hett</b> Middle <b>W. Hett</b> Last		15. MOTHER'S MAIDEN NAME First <b>Mary O. Anthor-Samers</b> Middle <b>H</b> Last <b>15A</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-35-3971</b>		17. INFORMANT <b>Mary O. Anthor-Samers</b> Address <b># 15A</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Superficial Abscesses of Skin</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senilis arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>months.</b> <b>years.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1967</b> , to <b>Feb 8, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Feb 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Max C Frank</b>		22c. DATE SIGNED <b>2/8/68</b>		22d. PHYSICIAN'S NAME (Type) <b>MAX C FRANK</b>	
22e. ADDRESS <b>425 SE Ritchie Hwy - Glen Burnie Md 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/12/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Piney Church Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Waldorf, Maryland</b>					
24. FUNERAL DIRECTOR <b>Robert R. Singleton</b>		24a. ADDRESS <b>Robert R. Singleton - Home/Henrieville, Md.</b>		25a. RECEIVED BY REGISTRAR <b>FEB 13 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

03008

03008

03013

CHATELAIN PAPER

20% COTTON FIBRE  
MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>LANCASTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>						c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE STONE 22578</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE EUGENIA HINSON</u>						4. DATE OF DEATH <u>FEB 29 1968</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 29 1875</u>		9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID BARTLETT WHITE</u>						14. MOTHER'S MARDEN NAME <u>ELLEN SUSAN THOMAS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. BLANCHE CODY</u>				Address <u>SHADY SIDE, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4109</u> IMMEDIATE CAUSE (a) <u>Acute myocardia infarction</u> DUE TO (b) <u>arteriosclerotic Cardiovascular disease 1-2 hours</u> stating the underlying cause last. (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 21, 1968</u> to <u>Feb 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 21 1968</u> , and that death occurred at <u>11:55 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>R M Smith</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 29, 1968</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-3-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church</u>				23d. LOCATION (City or Town) (County) (State) <u>White Stone, Virginia</u>			
24. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u> <u>HOME</u>						ADDRESS <u>6500 YORK RD</u> <u>BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03014

03282

STATE OF OHIO

IN SENATE,  
January 1, 1901.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE,  
MAY 1, 1899.  
COLUMBUS:  
THE STATE PRINTING  
OFFICE,  
1901.

RECEIVED  
JAN 1 1901  
STATE OF OHIO  
LAND OFFICE  
COLUMBUS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02015

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02003

1. DECEASED-NAME (Type or print) <b>DOON</b>		First <b>DOON</b>		Middle <b>LEROY</b>		Last <b>HOUCK</b> <del>XXXXX</del> Jr.		2a. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>7:45 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>February 27, 1968</b>			6. AGE (In years lost birthday) YRS. <b>1</b>		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>		IF UNDER 24 HRS. HOURS <b>1</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>A.A. Gen. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.						
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>A.A. Gen. Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>303 Mary Lou Ave.</b>				
14. FATHER'S NAME First <b>Don</b> Middle <b>L.</b> Last <b>Houck, Sr.</b>		15. MOTHER'S MAIDEN NAME First <b>Shirley</b> Middle <b>Szymborski</b> Last <b>Szymborski</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>none</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Shirley Houck (mother) Same as #13</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Since Birth</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Raymond P. Srsic, M.D.</b>		22c. DATE SIGNED <b>2/29/68</b>										
22d. PHYSICIAN'S NAME (Type) <b>Raymond P. Srsic, M.D.</b>		22e. ADDRESS <b>48 Balto-Annap. Blvd., Severna Park, Md</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar 1, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Men. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Maryland</b>						
24. FUNERAL DIRECTOR <b>R. V. Singleton</b>		ADDRESS <b>Glen Burnie, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

02004

02012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02016												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												02644											
1. DECEASED-NAME (Type or print) <u>CATHERINE S. HOWARD</u>												2a. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>68</u>												2b. HOUR <u>1 A.</u> M.											
3. SEX <u>F</u>				4. RACE <u>W</u>				5. DATE OF BIRTH <u>6-15-1916</u>				6. AGE (In years lost birthday) <u>51</u> YRS.				IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>				IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>															
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <u>ANNE ARUNDEL</u> Md.																							
10. CITY OR TOWN OF DEATH <u>RURAL-ANNAPOLIS</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>OLD ANNAPOLIS BLVD.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired.) <u>HOMEWIFE</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>				13b. COUNTY <u>A.A.</u>				13c. CITY OR TOWN <u></u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <u>RT #5 Box 14</u>																			
14. FATHER'S NAME First <u>C</u> Middle <u>KEEFER</u> Last <u>STALEY</u>				15. MOTHER'S MAIDEN NAME First <u>Lucy</u> Middle <u>I.</u> Last <u>KEMP</u>																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) <u>-</u>				16b. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>WALTON I. HOWARD</u> Address <u>#130</u>																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u> <u>150X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>150X</u>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>																											
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>Feb</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>2/11</u> , 19 <u>68</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <u>John W. Hedeman</u> MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <u>2/13/68</u>																							
22d. PHYSICIAN'S NAME (Type) <u>JOHN W. HEDEMAN</u>												22e. ADDRESS <u>FOREST DR. ANNAPOLIS, MD.</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE <u>2-15-68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>				23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>																							
24. FUNERAL DIRECTOR <u>John M. Layton</u> <u>Annapolis, Md.</u>												25a. REC'D BY REGISTRAR <u>DALE</u> DATE <u>FEB 16 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles</u>																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>5 mon.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor, Cecil Ave.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u> d. STREET ADDRESS <u>105 Hammonds Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>MINNIE</u> First <u>Elizabeth</u> Middle <u>HOWARD</u> Last						<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>1</u> Year <u>1968</u>									
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-5-1886</u>		<b>9. AGE (In years last birthday)</b> <u>81</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>26</u>		<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>? Rau</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u></u>				<b>17. INFORMANT</b> <u>Mr. Raymond J. Howard</u> Address <u>105 Hammonds Lane 21225</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Left ventricular failure</u> <u>470X</u> DUE TO <u>Acute Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Flu like syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized arteriosclerosis</u> <u>481X</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Hours</u> <u>Days</u> <u>Days</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u></u> e.m. <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town)</b> <u></u> (County) <u></u> (State) <u></u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 16, 1967</u> <b>to</b> <u>Feb 1, 1968</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 1, 1968</u> , <b>and that death occurred at</b> <u>2:45 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Max C Frank</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>2/1/68</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>MAX C FRANK MD</u>						<b>22d. ADDRESS</b> <u>425 SE Ripley Hwy - Glen Burnie Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/5/68</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u>				<b>23d. LOCATION (City, town or county)</b> <u>Balto. Md.</u> (State) <u></u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCall Funeral Home</u>						<b>ADDRESS</b> <u>237 Patapsco Ave. 21225</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 6 1968</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Alfred			Middle T.			Last Ingham			2a. DATE OF DEATH Month Day Year 2 18 68			2b. HOUR 2:20 PM		
3. SEX M			4. RACE W			5. DATE OF BIRTH 12-16-1869			6. AGE (In years last birthday) 98 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) England			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.								
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Annapolis Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipbuilder			12b. KIND OF BUSINESS OR INDUSTRY Construction								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.			13b. COUNTY A.A.			13c. CITY OR TOWN SHERWOOD FOREST			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER SHERWOOD FOREST					
14. FATHER'S NAME First Middle Last LATHORIA B. INGHAM						15. MOTHER'S MAIDEN NAME First Middle Last UNK.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.			17. INFORMANT Annapolis Nursing Home			Address # 11					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Arteriole hyaline sclerosis</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 11 / 19 66, to 2 / 19 68, that (I) (we) lost saw the deceased alive on 19 / 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE R. Brein												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/18/68			
22d. PHYSICIAN'S NAME (Type) A BREIN						22e. ADDRESS CATHEDRAL ST. Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2-21-68			23c. NAME OF CEMETERY OR CREMATORY CHESTER RURAL CEMT			23d. LOCATION (City or Town) (County) (State) Chester Del. Pa.								
24. FUNERAL DIRECTOR John M. Layton & Sons Annapolis, Md						25a. REC'D BY REGISTRAR DATE FEB 21 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jones								



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02019

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02007

1. DECEASED-NAME (Type or Print) <i>Stacie M. Jack</i>			2a. DATE KNOWN OF DEATH Month <i>2</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>P</i> M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>OCT. 30, 1923</i>	6. AGE (in years) <i>44</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>5</i> Year <i>1968</i>			2d. HOUR <i>P</i> M
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>AAPO</i> Md.			
10. CITY OR TOWN OF DEATH <i>PASADENA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Box 344 - Dogwood Rd</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Employee</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Beth-Steel</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>AAPO</i>		13c. CITY OR TOWN <i>Milleville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Dogwood Rd Box 344</i>
14. FATHER'S NAME First <i>Arley</i> Middle <i>Jack</i> Last <i>Wimer</i>			15. MOTHER'S MAIDEN NAME First <i>Lura</i> Middle <i>Wimer</i> Last <i>Wimer</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>229-20-2387</i>		17. INFORMANT <i>MRS Dorothy M. Jack (Wife)</i>			ADDRESS <i>same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Low back wound stroke</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>955x</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>976x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Stroke</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <i>2/5/68</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>2/5 1968</i> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18) <i>Self Inflamed Gun Shot wound Skull</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. L. H. H. H.</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>2/5/68</i>	
EXAMINER'S NAME (Type) <i>E. L. H. H. H.</i>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>AAPO</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-8-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wimer Cemetery</i>		23d. LOCATION (City or Town) <i>Blue Grass, Va.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>E. B. Johnson</i>			ADDRESS <i>Singston Funeral Home, Glen Burnie Md</i>			25a. REC'D BY REGISTRAR DATE <i>FEB 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

03001

REGION EXAMINER - J. H. BATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Margaretta</b>			First <b>F.</b> Middle <b>J.</b> Last <b>Jacobus</b>			2a. DATE OF DEATH <b>Feb.</b> Month <b>24</b> Day <b>68</b> Year		2b. HOUR <b>9:10</b> P <b>M</b>		
3. SEX <b>F</b>		4. RACE <b>Caus.</b>		5. DATE OF BIRTH <b>Oct. 9 1889</b>		6. AGE (In years lost birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>N.J.</b>			13b. COUNTY <b>Mountclair</b>		13c. CITY OR TOWN <b>Mountclair</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>22 St. Lukes Place</b>	
14. FATHER'S NAME <b>Hugh Grant Fraser</b>			First <b>Hugh</b> Middle <b>Grant</b> Last <b>Fraser</b>			15. MOTHER'S MAIDEN NAME <b>Welsh</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>150-36-1119</b>		17. INFORMANT <b>George Cawley</b> Address <b>19 Clover Court Cedar Grove N.J.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 min.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>C. Dorkan, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/24/1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Cenap Dorkan, M.D.</b>		22e. ADDRESS <b>320 Hospital Drive, Glen Burnie, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bloomfield Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bloomfield New Jersey</b>				
24. FUNERAL DIRECTOR <b>Wm. F. Tichner Sons North &amp; Ave. Balt.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02021

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02602

1. DECEASED-NAME (Type or print) <b>WILLIAM</b> <sup>First</sup> <b>GLENWOOD</b> <sup>Middle</sup> <b>JAMES</b> <sup>Last</sup>		2a. DATE OF DEATH <b>February</b> <sup>Month</sup> <b>2</b> <sup>Day</sup> <b>1968</b> <sup>Year</sup>		2b. HOUR <b>1:30</b> <sup>P.</sup> <b>1:30</b> <sup>M.</sup>	
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>July 27-1900</b>		6. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR MONTHS <b>67</b> DAYS <b>67</b> HOURS <b>67</b> MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Anne Arundel</b> <sup>Md.</sup>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>32 Pleasant Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer - Retired U.S. Naval Acad.</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>32 Pleasant Street</b>	
14. FATHER'S NAME <sup>First</sup> <b>William Thomas James</b> <sup>Middle</sup> <sup>Last</sup>		15. MOTHER'S MAIDEN NAME <sup>First</sup> <b>Carrie Soderia Blas</b> <sup>Middle</sup> <sup>Last</sup>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give year or dates of service) <b>W.W.I</b>	16b. SOCIAL SECURITY NO. <b>212-16-0339</b>	17. INFORMANT <sup>Address</sup> <b>Emma R. James-32 Pleasant St. Annapolis, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>526X</b> (b) <b>Bronchiectasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>3 years</b> <b>20 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Pyelonephritis, Uremia</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>2</b> Day <b>11</b> Year <b>1968</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <b>211</b> City or Town <b>Annapolis</b> County <b>Anne Arundel</b> State <b>Md.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>67</b> , to <b>2/11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard E. Cook</b>		DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/2/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Richard E. Cook</b>		22e. ADDRESS <b>20 Dean St. Annapolis, Md.</b>			
23a. BURIAL, CREMATION, BURNING (Specify) <b>Burial</b>	23b. DATE <b>Feb. 5-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>	23d. LOCATION (City or Town) <b>Annapolis</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>C.F. Hicks 111 43-45 Northwest Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02022

02010

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B.O.A. A.A. General</u>		d. STREET ADDRESS <u>508 Annapolis Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Johnnie (John) Johnson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>214-052397</u>	
17. INFORMANT <u>Lillian Johnson</u>		Address <u>Annapolis, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>11:57 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Reese</u>		22b. DATE SIGNED <u>2/28/68</u>	22c. PHYSICIAN'S NAME (Type) <u>  </u>
22d. ADDRESS <u>  </u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-1-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md</u>
24. FUNERAL DIRECTOR <u>William Reese #</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02023										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02011																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last Richard T Johnson										Month Day Year 2 14 1968										10 P. M.																			
3. SEX Male					4. RACE White					5. DATE OF BIRTH 5-5-1895					6. AGE (In years lost birthday) 72 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel Md.																								
10. CITY OR TOWN OF DEATH Glen Burnie					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) City Police					12b. KIND OF BUSINESS OR INDUSTRY Police																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.					13b. COUNTY Baltimore					13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 1341 Hull ST.																			
14. FATHER'S NAME First Middle Last George Johnson					15. MOTHER'S MAIDEN NAME First Middle Last Katherine White																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes					16b. SOCIAL SECURITY NO. 51011-5415 218-36-4769					17. INFORMANT Mrs. Barbara Johnson					Address 1341 Hull ST.																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-14</u> , 19 <u>68</u> , to <u>2-14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-14-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>William M. Winkler</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 2-14-68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
23a. BURIAL, CREMATION, REMOVAK (Specify) Burial										23b. DATE 2/19/68										23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue										25a. REC'D BY REGISTRAR DATE FEB 23 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																			

MEDICAL CERTIFICATION

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But my original position  
is not to be changed.

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My dear Mr. [unclear]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

<div>02024</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02012</div>											
1. DECEASED-NAME (Type or print) <b>Clarence H. Jones</b>						2a. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>2:57 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-7-04</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundal</b> Md.					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundal</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cabinet Maker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundal</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>31 First Ave., Marley</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-18-7994</b>		17. INFORMANT Address <b>Mrs. Ellen B. Jones, same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute massive coronary thrombosis with dysrhythmia</b> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4201 ruptured left posterior myocardium</b> (b) <b>myocardium</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hepatic insufficiency</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>68</b> , to <b>2/15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Benjamin G. de Guzman</b>						22c. DATE SIGNED <b>2/15/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>B. A. de GUZMAN, MD.</b>						22e. ADDRESS <b>325 HOSPITAL Dr. Suite 108 GLEN BURNIE, Md. 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>19 Feb. 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, AA, Md.</b>					
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Report on the progress of the work done during the year 1900.

2/12 2/12 2/12 2/12 2/12

8/2/28



Chapman, D. S.

18. A. de Cuyper, 1892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
02025													
02013													
1. DECEASED-NAME (Type or print) <u>FLETCHER</u> <u>S.</u> <u>Joyce</u>						2a. DATE OF DEATH <u>2</u> Month <u>24</u> Day <u>68</u>			2b. HOUR <u>M</u>				
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>3-1-1904</u>			6. AGE (In years last birthday) <u>63</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>ANNE ARUNDEL</u> Md.						
10. CITY OR TOWN OF DEATH <u>MILBERSVILLE</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>INDIAN HANDING ROAD</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>FARM</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>			13b. COUNTY <u>A.A.</u>		13c. CITY OR TOWN <u>MILBERSVILLE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>INDIAN HANDING RD.</u>				
14. FATHER'S NAME First <u>ELMORE</u> Middle <u>F.</u> Last <u>Joyce</u>			15. MOTHER'S MAIDEN NAME First <u>KATHERINE</u> Middle <u>B.</u> Last <u>MORGAN</u>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>LOUISE S. JOYCE #13E.</u> Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Prostate &amp; Bladder.</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>185X</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>2-24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>2-12</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>T. G. OSIUS M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type) <u>T. G. OSIUS</u>						22e. ADDRESS <u>77 Front In St Annap.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2-27-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALDWIN MEMORIAL</u>		23d. LOCATION (City or Town) (County) (State) <u>MILBERSVILLE A.A. MD.</u>							
24. FUNERAL DIRECTOR <u>John M. Lytton Sons Annapolis, Mdo</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

NO POSTAGE IS NECESSARY IF MAILED IN THE UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tag and paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First Nicholas			Middle E.			Last Karastamatis			2a. DATE OF DEATH Month Day Year February 11, 1968			2b. HOUR M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH 2-1-96			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Turkey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel			Md.				
10. CITY OR TOWN OF DEATH Severna Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Half-way House, Rt. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR INDUSTRY Rest.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Severna Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Half-way House, Rt. 2				
14. FATHER'S NAME Emmanuel			First Middle Last Karastamatis			15. MOTHER'S MAIDEN NAME Chrysoula Gijigirik			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.			17. INFORMANT James Karastamatis			Address 7856 Bruton Drive, Glen Burnie, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/68</u> , 19 <u>68</u> , to <u>2/11/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/9/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Edmond I. Moushabeck</u>			DEGREE EDMOND I. MOUSHABEK			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/12/68							
22d. PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK			22e. ADDRESS 510 MARLEY STATION ROAD GLEN BURNIE, Md. 21061													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2-14-68			23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR Nicholas T. Matthews,			ADDRESS 3021 Eastern Ave Baltimore, Md.			25a. REC'D BY REGISTRAR DATE FEB 16 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



41080

02030

FEB 10 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02027					02015				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)				
a. COUNTY		ARMED ARUNDEL MARYLAND			a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pasadena		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
D. O. A. North Arundel General Hospital					60 Johnson Road 21122		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
Evelyn		S.		Kellum		February 17 1968		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
female		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/24/1906		61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						Maryland		U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
August Kletter					Eva Slett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				Address
No					Mr. Charles M. Kellum				60 Johnson Road 21122
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction									1 hour
4129 DUE TO (b) Atherosclerotic cardiovascular disease									4 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED?
4201 none									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (the hospital) attended the deceased from 9/20, 1936, to 2/17, 1968, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
R. M. McLaughlin							2/17/68		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
R. M. McLaughlin M.D.					3708 Monitani Rd. Pasadena, Md. 21122				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		2/21/68		Meadowridge Memorial Park		Howard Co. Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
McCully F. H.					237 Patpasco Ave. 21225		DATED 21 1968		Charles J. [Signature]

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Johnston Road

North Atlantic

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CERTIFICATE OF DEATH

02016

1. DECEASED-NAME (Type or print) <b>Katherine Kerruish</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>1:20AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>14 Apr 67</b>		6. AGE (In years last birthday) YRS. <b>10</b> MONTHS <b>10</b> DAYS <b>10</b> HOURS <b>10</b> MIN.	
7a. BIRTHPLACE (State or foreign county) <b>South Bend, Ind.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.	
10. CITY OR TOWN OF DEATH <b>Ft Geo G. Meade, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital state nearest place) <b>Kimberly Army Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>13018 Old Stage Coach Rd.</b>		14. FATHER'S NAME First Middle Last <b>Kenneth Kerruish</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>BETTY Snyder</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Kenneth Kerruish(F)</b>		Address <b>Same as # 13c &amp; e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Deferred until microscopic examination</b> <b>466X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>completed</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchiolitis &amp; interstitial pneumonitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491X</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9 Feb</b> , 19 <b>68</b> , to <b>10 Feb</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Murray O Corbin MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>10 February 1968</b>	
22d. PHYSICIAN NAME (Type) <b>ROBERT L. CULLEN, CPT, MC</b>						22e. ADDRESS <b>Kimberly Army Hospital, FGGMMD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>		23d. LOCATION (City or Town) (County) (State) <b>South Bend Indiana</b>	
24. FUNERAL DIRECTOR <b>Howard County</b> <b>Funeral Home of Harry Witzke Ellicott City Md.</b>				25a. REC'D BY REGISTRAR DATE <b>1-13-1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

#1050

25080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02029

CERTIFICATE OF DEATH

02017

1. DECEASED-NAME (Type or print) First Middle Last Raymond S. KETTLEWELL			2a. DATE OF DEATH Month Day Year 2-22-68		2b. HOUR 6:06 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-28-13		6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician	12b. KIND OF BUSINESS OR INDUSTRY Local #26	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER (Marley Park) 409 Old Annapolis Rd.	
14. FATHER'S NAME First Middle Last (unknown) Kettlewell		15. MOTHER'S MAIDEN NAME First Middle Last Nancy Jane Sweeney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. 0931-34	17. INFORMANT Address Mrs. Nellie P. Kettlewell (wife) Same as #1		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-16-1968, to 2-22-1968, that (I) (we) lost saw the deceased alive on 2-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Asa M. [Signature]</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-22-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 26 1968	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR E. B. Fleming		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 26 1968	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



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5-55-4 2 *[Signature]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>4</div> <div>1</div> <div>02030</div> <div>02018</div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR		A.	
First Middle Last <b>Katherine Stark KOEHL</b>						Month Day Year <b>February 14 1968</b>		<b>6:20 M</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<b>F</b>		<b>W</b>		<b>8-23-1883</b>		<b>84</b> YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
<b>VA.</b>			<b>U.S.</b>				<b>Anne Arundel Md.</b>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<b>Annapolis</b>			<b>A.A. GENERAL HOSP.</b>			<b>Housewife</b>			<b>HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
<b>MD.</b>			<b>A.A.</b>		<b>EDGEWATER</b>		<b>NO</b>		<b>LOU DON TOWNE</b>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
<b>William F. Colvin</b>			<b>Elizabeth Hudson</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
<b>NO</b>			<b>212 52 6465</b>		<b>MRS. R. SCOTT # 130</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Pneumonia</b>										<b>3 days</b>	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										<b>1 week</b>	
(b) <b>Cerebral thrombosis</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<b>332X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
		<b>19</b>									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>67</b> , to <b>2/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/14/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<b>General Counsel</b>		<b>2/15/68</b>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<b>General Counsel</b>		<b>121 Cantonment St Annapolis Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<b>BURIAL</b>		<b>2-16-68</b>		<b>Ft. Lincoln</b>		<b>Bladensburg MD</b>					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<b>John M. Lyons</b>		<b>Annapolis, Md</b>		<b>FEB 16 1968</b>		<b>John M. Lyons</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02031										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02619																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
Richard T. Lambeth										Month 2 Day 8 Year 68										10:05 P.M.																			
3. SEX Male										4. RACE White										5. DATE OF BIRTH 12-31-1899										6. AGE (In years last birthday) 68 YRS.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.									
10. CITY OR TOWN OF DEATH Glen Burnie										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Plaza Maria Nursing Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer										12b. KIND OF BUSINESS OR INDUSTRY Shipyard									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Baltimore										13c. CITY OR TOWN Glen Burnie										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER 700 WILKINSON ST.										14. FATHER'S NAME First Middle Last Richard M. Lambeth										15. MOTHER'S MAIDEN NAME First Middle Last Annie E. Carr																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 217-03-023										17. INFORMANT (B. Sister) Marie Harper 1716 BROAD ST. CLARKS																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Coronary Occlusion																				Seven hrs																			
410.0 DUE TO, OR AS A CONSEQUENCE OF																																							
(b) Myocardial Infarction																				Unknown																			
DUE TO, OR AS A CONSEQUENCE OF																																							
(c) Hypertensive Cardio-Vascular Disease																				Unknown																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
4201																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 6-13, 1967, to 2-8, 1968, that (I) (we) last saw the deceased alive on 2-8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Richard H. Hunt M.D. DEGREE										22c. DATE SIGNED 2 9 68																													
22d. PHYSICIAN'S NAME (Type) Richard H. Hunt										22e. ADDRESS 100 Cherry Lane Glen Burnie, Md																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE FEB 12 1968										23c. NAME OF CEMETERY OR CREMATORY CROFT HILL CEMETERY																			
23d. LOCATION (City or Town) (County) (State) Crofton A.A. Co. Md										24. FUNERAL DIRECTOR CURTIS E. EVANS ADDRESS 1400 S. CHAPMAN ST BALTIMORE 21230										25a. REC'D BY REGISTRAR DATE FEB 13 1968																			
25b. REGISTRAR'S SIGNATURE Charles Judge																																							

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21 (M)  
FOR STATE  
HEALTH DEPT.

02032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02020

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI DEATH MATED		Month	Day	Year	2b. HOUR
ADA				LARKIN	<input checked="" type="checkbox"/>		2	19	1980	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c. DATE PRONOUNCED DEAD Month	
F	N	12-13-1924		43 YRS.					2 Day 19 Year 1980	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Md.		U.S.A.				Adco				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		DON W. Jew. Hosp.		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD		Anco		Annapolis				74 W. WASHINGTON.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Henry			Worsey		Ada			Worsey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
				Howard Larkin		74 W. Washington				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3032 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3221										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2/19/88		
F. L. in back St.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Adco		
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-24-98		Pine Lawn Memorial		Annapolis Md				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
William Reesett		Arma, Md		FEB 23 1988		Charles Judge				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05086

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1950



05086



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02033

02021

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR HRS. MIN.	
Charles		L.		Larkin	Feb. 19 1968		8A. M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male	White		July 9, 1905		62 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.	U.S.A.				Anne Arundle Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Orchard Beach		7821 Waterview Drive		Real Estate		self-employ		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.		Anne Ar.		Orchard B				7821 Waterview Drive
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Wm. F. Larkin		Elsie N. Pfeifer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no		none		215-22-9639 Margaret Larkin 7821 Waterview Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma</u> 160.8 DUE TO, OR AS A CONSEQUENCE OF <u>of right frontal sinus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>160.7</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>metastase to right eyeball anteriorly adjuvantly</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>April 1966</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
DR ISAAC MILLER		1228 So. Charles ST						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/22/68		Cedar Hill Cemetery		Ritchie Highway Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
KRAUSE FUNERAL HOME		1216 S. Charles St.		DATE FEB 21 1968		Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12080

0803

0803

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02034

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02021

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNAPOHIS</b> c. LENGTH OF STAY IN 1b <b>ANNAPOLIS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>116 Conduit St.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> d. STREET ADDRESS <b>116 Conduit St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b> First Middle Last 4. DATE OF DEATH <b>2 15 1968</b> Month Day Year				5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>12-23/1903</b> 9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b> 11. BIRTHPLACE (County & State, or foreign country) <b>N.Y. STATE</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>ETHEL MCGONIGAL</b> 14. MOTHER'S MAIDEN NAME <b>MABEL DUNNING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>—</b> 17. INFORMANT <b>RICHARD MCGONIGAL</b> <b>CATHER ST. PALMYRA N.Y.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DOA</b> 571.9 <b>581.0</b> <b>582.0</b> <b>583.0</b> <b>584.0</b> <b>585.0</b> <b>586.0</b> <b>587.0</b> <b>588.0</b> <b>589.0</b> <b>590.0</b> <b>591.0</b> <b>592.0</b> <b>593.0</b> <b>594.0</b> <b>595.0</b> <b>596.0</b> <b>597.0</b> <b>598.0</b> <b>599.0</b> <b>600.0</b> <b>601.0</b> <b>602.0</b> <b>603.0</b> <b>604.0</b> <b>605.0</b> <b>606.0</b> <b>607.0</b> <b>608.0</b> <b>609.0</b> <b>610.0</b> <b>611.0</b> <b>612.0</b> <b>613.0</b> <b>614.0</b> <b>615.0</b> <b>616.0</b> <b>617.0</b> <b>618.0</b> <b>619.0</b> <b>620.0</b> <b>621.0</b> <b>622.0</b> <b>623.0</b> <b>624.0</b> <b>625.0</b> <b>626.0</b> <b>627.0</b> <b>628.0</b> <b>629.0</b> <b>630.0</b> <b>631.0</b> <b>632.0</b> <b>633.0</b> <b>634.0</b> <b>635.0</b> <b>636.0</b> <b>637.0</b> <b>638.0</b> <b>639.0</b> <b>640.0</b> <b>641.0</b> <b>642.0</b> <b>643.0</b> <b>644.0</b> <b>645.0</b> <b>646.0</b> <b>647.0</b> <b>648.0</b> <b>649.0</b> <b>650.0</b> <b>651.0</b> <b>652.0</b> <b>653.0</b> <b>654.0</b> <b>655.0</b> <b>656.0</b> <b>657.0</b> <b>658.0</b> <b>659.0</b> <b>660.0</b> <b>661.0</b> <b>662.0</b> <b>663.0</b> <b>664.0</b> <b>665.0</b> <b>666.0</b> <b>667.0</b> <b>668.0</b> <b>669.0</b> <b>670.0</b> <b>671.0</b> <b>672.0</b> <b>673.0</b> <b>674.0</b> <b>675.0</b> <b>676.0</b> <b>677.0</b> <b>678.0</b> <b>679.0</b> <b>680.0</b> <b>681.0</b> <b>682.0</b> <b>683.0</b> <b>684.0</b> <b>685.0</b> <b>686.0</b> <b>687.0</b> <b>688.0</b> <b>689.0</b> <b>690.0</b> <b>691.0</b> <b>692.0</b> <b>693.0</b> <b>694.0</b> <b>695.0</b> <b>696.0</b> <b>697.0</b> <b>698.0</b> <b>699.0</b> <b>700.0</b> <b>701.0</b> <b>702.0</b> <b>703.0</b> <b>704.0</b> <b>705.0</b> <b>706.0</b> <b>707.0</b> <b>708.0</b> <b>709.0</b> <b>710.0</b> <b>711.0</b> <b>712.0</b> <b>713.0</b> <b>714.0</b> <b>715.0</b> <b>716.0</b> <b>717.0</b> <b>718.0</b> <b>719.0</b> <b>720.0</b> <b>721.0</b> <b>722.0</b> <b>723.0</b> <b>724.0</b> <b>725.0</b> <b>726.0</b> <b>727.0</b> <b>728.0</b> <b>729.0</b> <b>730.0</b> <b>731.0</b> <b>732.0</b> <b>733.0</b> <b>734.0</b> <b>735.0</b> <b>736.0</b> <b>737.0</b> <b>738.0</b> <b>739.0</b> <b>740.0</b> <b>741.0</b> <b>742.0</b> <b>743.0</b> <b>744.0</b> <b>745.0</b> <b>746.0</b> <b>747.0</b> <b>748.0</b> <b>749.0</b> <b>750.0</b> <b>751.0</b> <b>752.0</b> <b>753.0</b> <b>754.0</b> <b>755.0</b> <b>756.0</b> <b>757.0</b> <b>758.0</b> <b>759.0</b> <b>760.0</b> <b>761.0</b> <b>762.0</b> <b>763.0</b> <b>764.0</b> <b>765.0</b> <b>766.0</b> <b>767.0</b> <b>768.0</b> <b>769.0</b> <b>770.0</b> <b>771.0</b> <b>772.0</b> <b>773.0</b> <b>774.0</b> <b>775.0</b> <b>776.0</b> <b>777.0</b> <b>778.0</b> <b>779.0</b> <b>780.0</b> <b>781.0</b> <b>782.0</b> <b>783.0</b> <b>784.0</b> <b>785.0</b> <b>786.0</b> <b>787.0</b> <b>788.0</b> <b>789.0</b> <b>790.0</b> <b>791.0</b> <b>792.0</b> <b>793.0</b> <b>794.0</b> <b>795.0</b> <b>796.0</b> <b>797.0</b> <b>798.0</b> <b>799.0</b> <b>800.0</b> <b>801.0</b> <b>802.0</b> <b>803.0</b> <b>804.0</b> <b>805.0</b> <b>806.0</b> <b>807.0</b> <b>808.0</b> <b>809.0</b> <b>810.0</b> <b>811.0</b> <b>812.0</b> <b>813.0</b> <b>814.0</b> <b>815.0</b> <b>816.0</b> <b>817.0</b> <b>818.0</b> <b>819.0</b> <b>820.0</b> <b>821.0</b> <b>822.0</b> <b>823.0</b> <b>824.0</b> <b>825.0</b> <b>826.0</b> <b>827.0</b> <b>828.0</b> <b>829.0</b> <b>830.0</b> <b>831.0</b> <b>832.0</b> <b>833.0</b> <b>834.0</b> <b>835.0</b> <b>836.0</b> <b>837.0</b> <b>838.0</b> <b>839.0</b> <b>840.0</b> <b>841.0</b> <b>842.0</b> <b>843.0</b> <b>844.0</b> <b>845.0</b> <b>846.0</b> <b>847.0</b> <b>848.0</b> <b>849.0</b> <b>850.0</b> <b>851.0</b> <b>852.0</b> <b>853.0</b> <b>854.0</b> <b>855.0</b> <b>856.0</b> <b>857.0</b> <b>858.0</b> <b>859.0</b> <b>860.0</b> <b>861.0</b> <b>862.0</b> <b>863.0</b> <b>864.0</b> <b>865.0</b> <b>866.0</b> <b>867.0</b> <b>868.0</b> <b>869.0</b> <b>870.0</b> <b>871.0</b> <b>872.0</b> <b>873.0</b> <b>874.0</b> <b>875.0</b> <b>876.0</b> <b>877.0</b> <b>878.0</b> <b>879.0</b> <b>880.0</b> <b>881.0</b> <b>882.0</b> <b>883.0</b> <b>884.0</b> <b>885.0</b> <b>886.0</b> <b>887.0</b> <b>888.0</b> <b>889.0</b> <b>890.0</b> <b>891.0</b> <b>892.0</b> <b>893.0</b> <b>894.0</b> <b>895.0</b> <b>896.0</b> <b>897.0</b> <b>898.0</b> <b>899.0</b> <b>900.0</b> <b>901.0</b> <b>902.0</b> <b>903.0</b> <b>904.0</b> <b>905.0</b> <b>906.0</b> <b>907.0</b> <b>908.0</b> <b>909.0</b> <b>910.0</b> <b>911.0</b> <b>912.0</b> <b>913.0</b> <b>914.0</b> <b>915.0</b> <b>916.0</b> <b>917.0</b> <b>918.0</b> <b>919.0</b> <b>920.0</b> <b>921.0</b> <b>922.0</b> <b>923.0</b> <b>924.0</b> <b>925.0</b> <b>926.0</b> <b>927.0</b> <b>928.0</b> <b>929.0</b> <b>930.0</b> <b>931.0</b> <b>932.0</b> <b>933.0</b> <b>934.0</b> <b>935.0</b> <b>936.0</b> <b>937.0</b> <b>938.0</b> <b>939.0</b> <b>940.0</b> <b>941.0</b> <b>942.0</b> <b>943.0</b> <b>944.0</b> <b>945.0</b> <b>946.0</b> <b>947.0</b> <b>948.0</b> <b>949.0</b> <b>950.0</b> <b>951.0</b> <b>952.0</b> <b>953.0</b> <b>954.0</b> <b>955.0</b> <b>956.0</b> <b>957.0</b> <b>958.0</b> <b>959.0</b> <b>960.0</b> <b>961.0</b> <b>962.0</b> <b>963.0</b> <b>964.0</b> <b>965.0</b> <b>966.0</b> <b>967.0</b> <b>968.0</b> <b>969.0</b> <b>970.0</b> <b>971.0</b> <b>972.0</b> <b>973.0</b> <b>974.0</b> <b>975.0</b> <b>976.0</b> <b>977.0</b> <b>978.0</b> <b>979.0</b> <b>980.0</b> <b>981.0</b> <b>982.0</b> <b>983.0</b> <b>984.0</b> <b>985.0</b> <b>986.0</b> <b>987.0</b> <b>988.0</b> <b>989.0</b> <b>990.0</b> <b>991.0</b> <b>992.0</b> <b>993.0</b> <b>994.0</b> <b>995.0</b> <b>996.0</b> <b>997.0</b> <b>998.0</b> <b>999.0</b> <b>1000.0</b> <b>1001.0</b> <b>1002.0</b> <b>1003.0</b> <b>1004.0</b> <b>1005.0</b> <b>1006.0</b> <b>1007.0</b> <b>1008.0</b> <b>1009.0</b> <b>1010.0</b> <b>1011.0</b> <b>1012.0</b> <b>1013.0</b> <b>1014.0</b> <b>1015.0</b> <b>1016.0</b> <b>1017.0</b> <b>1018.0</b> <b>1019.0</b> <b>1020.0</b> <b>1021.0</b> <b>1022.0</b> <b>1023.0</b> <b>1024.0</b> <b>1025.0</b> <b>1026.0</b> <b>1027.0</b> <b>1028.0</b> <b>1029.0</b> <b>1030.0</b> <b>1031.0</b> <b>1032.0</b> <b>1033.0</b> <b>1034.0</b> <b>1035.0</b> <b>1036.0</b> <b>1037.0</b> <b>1038.0</b> <b>1039.0</b> <b>1040.0</b> <b>1041.0</b> <b>1042.0</b> <b>1043.0</b> <b>1044.0</b> <b>1045.0</b> <b>1046.0</b> <b>1047.0</b> <b>1048.0</b> <b>1049.0</b> <b>1050.0</b> <b>1051.0</b> <b>1052.0</b> <b>1053.0</b> <b>1054.0</b> <b>1055.0</b> <b>1056.0</b> <b>1057.0</b> <b>1058.0</b> <b>1059.0</b> <b>1060.0</b> <b>1061.0</b> <b>1062.0</b> <b>1063.0</b> <b>1064.0</b> <b>1065.0</b> <b>1066.0</b> <b>1067.0</b> <b>1068.0</b> <b>1069.0</b> <b>1070.0</b> <b>1071.0</b> <b>1072.0</b> <b>1073.0</b> <b>1074.0</b> <b>1075.0</b> <b>1076.0</b> <b>1077.0</b> <b>1078.0</b> <b>1079.0</b> <b>1080.0</b> <b>1081.0</b> <b>1082.0</b> <b>1083.0</b> <b>1084.0</b> <b>1085.0</b> <b>1086.0</b> <b>1087.0</b> <b>1088.0</b> <b>1089.0</b> <b>1090.0</b> <b>1091.0</b> <b>1092.0</b> <b>1093.0</b> <b>1094.0</b> <b>1095.0</b> <b>1096.0</b> <b>1097.0</b> <b>1098.0</b> <b>1099.0</b> <b>1100.0</b> <b>1101.0</b> <b>1102.0</b> <b>1103.0</b> <b>1104.0</b> <b>1105.0</b> <b>1106.0</b> <b>1107.0</b> <b>1108.0</b> <b>1109.0</b> <b>1110.0</b> <b>1111.0</b> <b>1112.0</b> <b>1113.0</b> <b>1114.0</b> <b>1115.0</b> <b>1116.0</b> <b>1117.0</b> <b>1118.0</b> <b>1119.0</b> <b>1120.0</b> <b>1121.0</b> <b>1122.0</b> <b>1123.0</b> <b>1124.0</b> <b>1125.0</b> <b>1126.0</b> <b>1127.0</b> <b>1128.0</b> <b>1129.0</b> <b>1130.0</b> <b>1131.0</b> <b>1132.0</b> <b>1133.0</b> <b>1134.0</b> <b>1135.0</b> <b>1136.0</b> <b>1137.0</b> <b>1138.0</b> <b>1139.0</b> <b>1140.0</b> <b>1141.0</b> <b>1142.0</b> <b>1143.0</b> <b>1144.0</b> <b>1145.0</b> <b>1146.0</b> <b>1147.0</b> <b>1148.0</b> <b>1149.0</b> <b>1150.0</b> <b>1151.0</b> <b>1152.0</b> <b>1153.0</b> <b>1154.0</b> <b>1155.0</b> <b>1156.0</b> <b>1157.0</b> <b>1158.0</b> <b>1159.0</b> <b>1160.0</b> <b>1161.0</b> <b>1162.0</b> <b>1163.0</b> <b>1164.0</b> <b>1165.0</b> <b>1166.0</b> <b>1167.0</b> <b>1168.0</b> <b>1169.0</b> <b>1170.0</b> <b>1171.0</b> <b>1172.0</b> <b>1173.0</b> <b>1174.0</b> <b>1175.0</b> <b>1176.0</b> 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Amnagoris

111 Conant St.

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12-23/1963

N.Y. State

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Richard McDonald, Attorney at Law, N.Y.

Amnagoris

111 Conant St.

W

F

Home

Housewife

McDonald

no

John M. McDonald, 2-17-68, ALMAZAR GENT, ALMAZAR N.Y.

N.Y.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02035

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02022

1. DECEASED NAME (Type or print) <b>Gunnar</b>		Middle <b>LEIFSON</b>		20. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1968</b>		2b. HOUR <b>7:15</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4-1-1900</b>		6. AGE (In years last birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Norway</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>F.A. General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Civil Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTRY <b>Anne Arundel/Harwood</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>Rt. 1 Box 179</b>	
14. FATHER'S NAME First <b>Alfred</b> Middle <b>T.</b> Last <b>Leifson</b>		15. MOTHER'S MAIDEN NAME First <b>Dagny</b> Middle <b>J.</b> Last <b>Midtgarden</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>1638</b>		17. INFORMANT <b>M.A. LEIFSON FF BBE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1638</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>62</b> , to <b>Feb 16</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Feb. 16</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> <del>(did not)</del> view the body after death.							
22b. SIGNATURE <b>Willard F. Smith</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>2/17/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Willard F. Smith MD</b>		22e. ADDRESS <b>Shady Side, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>2-19-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Bladensburg Md.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons</b>		ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>02036</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02624</div>													
1. DECEASED-NAME (Type or print) <b>TRUBADOUR</b>				First Middle Last <b>LEWIS</b>				2a. DATE OF DEATH Feb Month 6 Day 1968 Year				2b. HOUR 10 <sup>10</sup> AM	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>SEPT. 14, 1896</b>				6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MIDLOTHIAN, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.							
10. CITY OR TOWN OF DEATH <b>MILLERSVILLE, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>KNOLLWOOD MANOR</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SALESMAN-PAINT</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>PAINT STORE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>ALLEGANY CUMBERLAND</b>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>WINCHESTER ROAD</b>			
14. FATHER'S NAME First Middle Last <b>EDWARD LEWIS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY THOMAS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>214-05-6369</b>		17. INFORMANT <b>LAUREL, Address MR. DAVID LEWIS, 1105 WHITE WAY</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4369 Left ventricular failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram negative septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>days</b> <b>Months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>331X</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 24, 1967</b> , to <b>Feb 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Max C Frank MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/6/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MAX C FRANK MD</b>		22e. ADDRESS <b>425 SE Ritchie Hwy. Glen Burnie MD 21061</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB. 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>				23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>					
24. FUNERAL DIRECTOR <b>M. SOWERS, HAFER-SOWERS FUNERAL</b>				ADDRESS <b>60 W. MAIN, FROSTBURG</b>		25a. RECD BY REGISTRAR <b>DATE FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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15 NOV 1954

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18&22a Film 398  
3-7-68 ams  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>PATRICIA S. LLOYD</b>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 2 Day 13 Year 1968 4:pM			2b. HOUR			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-25-34</b>	6. AGE (In years last birthday) <b>33RS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD Month <b>February</b> Day 13 Year 1968 4:pM			2d. HOUR
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel Md.</b>			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>KEY PUNCH OPR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TAXI Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pasadena</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>Harry</b> Middle <b>Bob</b> Last <b>Myrtle</b>			15. MOTHER'S MAIDEN NAME First <b>Myrtle</b> Middle <b>?</b> Last <b>?</b>			13e. STREET AND NUMBER <b>Box 98 County Lefe Rd.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>10</b>		17. INFORMANT <b>Joseph Lloyd - Above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>486X</b> IMMEDIATE CAUSE (a) <b>Airway obstruction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute tracheitis at site of tracheostomy</b> DUE TO, OR AS A CONSEQUENCE OF <b>performed for pneumonia</b> (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>493X</b>									
19a. DATE OF OPERATION <b>1/7/68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Pneumonia</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward F. Wilson</b>			EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>February 14, 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie Md</b>		
24. FUNERAL DIRECTOR <b>Robert S. Baranow</b>			ADDRESS <b>Severna Park Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
02038						02026								
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
CHARLES			MANCK			2 Month 21 Day 68 Year			12:27 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		APRIL 13, 1912			55 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
BALTIMORE, MD.			U.S.A.						ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS			NORTH ARUNDEL GENERAL HOSP.			MERCHANT			SHOES RETAIL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
MARYLAND			ANNE ARUNDEL			ANNAPOLIS			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			788 C FAIRVIEW AVE., ANNAP.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
JOSEPH			MANCKOWITZ			LENA			KAPLAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
YES			W.W.II ARMY			MRS. BEATRICE MANCK			788 C FAIRVIEW AVE., ANNAP.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>											5 minutes.			
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery atherosclerosis</u>											10 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1956, to <u>Feb</u> , 1968, that (I) (we) lost saw the deceased alive on <u>Feb 14</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
<u>John L. Hedeman M.D.</u>			2/21/68			John L. Hedeman, M.D.			1407 Forest Drive, Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			2-22-68			OHEB SHALOM			BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
OL LEVINSON & BROS. INC.			6010 REISTERSTOWN RD.			FEB 23 1968			Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02039				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02027							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR P	
Claude James MARSTON										February 20 1968				6:40 M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		White		Jan. 10, 1912				56 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Virginia		U.S.				Anne Arundel									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis				Anne Arundel Gen. Hosp.				instructor				Driving			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Anne Arundel				Annapolis				20 Hilltop Lane			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
Samuel L. Marston										Virgie Hoover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address			
no				217-05-7241				Virginia W. Marston - same as #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aneurysm of Thoracic aorta</u> 4410 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451X															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 20</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>Feb 20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John L. Hedeman MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2/21/68							
22d. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.				22e. ADDRESS 1407 Forest Drive, Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Feb. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie A.A. Md.							
24. FUNERAL DIRECTOR Beverly E. Hopping Hopping Funeral Home - Annapolis, Md.				25a. REC'D BY REGISTRAR DATE FEB 26 1968				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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RECEIVED

TO THE DIRECTOR, BUREAU OF REVENUE  
WASHINGTON, D. C.  
FROM THE COMMISSIONER, BUREAU OF REVENUE  
WASHINGTON, D. C.  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
02040										
02028										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Robert			Henry Maury			Month Day Year February 27 1968		A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		December 9, 1890		77 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Va.		U.S.A.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis, Md.			Naval Hospital			U.S. NAVY		Ret.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		208 Prince George St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last GREENHAW MAURY MARY RUTHERFORD HERUIE			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES WWI+II					HAZEL S. MAURY #13E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia</u> <u>560.4</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Small bowel obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adhesion</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5705</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
28 Feb 68		Small bowel obstruction			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>20 December, 1967</u> , to <u>28 Feb.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>27 February</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>James J. Quinn</u> <u>LCDR MC USN</u> REGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2-28</u>		
22d. PHYSICIAN'S NAME (Type) J.J. QUINN, LCDR MC USN						22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)				
Burial		3-1-68		Arlington Nat'l		Arlington Va.				
24. FUNERAL DIRECTOR John M. Taylor & Sons, Duke of Gloucester St. Annapolis, Md.						25a. REC'D BY REGISTRAR DATE MAR 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Robert			Edward			Maxfield		Month 2	Day 19	
Year 68			7:15							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Aug. 1, 1890		28 77rs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore Co.		USA				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hospital			None Ice Man (Retr.)		Self-Emp		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Glen Burnie				210 D. Street SW	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Edward			Maxfield			Mary (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			None		212-30-9208A Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>myocardial insufficiency</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>arteriosclerosis</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Hypothyroidism</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>68</u> , to <u>2/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
<u>C. Driskow, M.D.</u>					2/20/68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Feb. 23, 1968		Baltimore Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Richard V. Singleton					FEB 23 1968		<u>Frank Judge</u>			

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CERTIFICATE OF DEATH

03050

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02042

02030

1. DECEASED-NAME (Type or print) <b>Pauline</b>			First <b>R</b>			Middle <b>May</b>			Last			2a. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>9:30 A.M.</b>		
3. SEX <b>Female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>I-3-1888</b>			6. AGE (In years last birthday) <b>80</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Oxford, N.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Patapsco Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Patapsco Park</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired-Mill Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>N.C.</b>			13b. COUNTY <b>Oxford</b>			13c. CITY OR TOWN <b>Oxford</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME <b>Henry Royster</b>			First <b>Henry</b>			Middle <b>Royster</b>			Last			15. MOTHER'S MAIDEN NAME <b>Martha Down</b>			First <b>Martha</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Will Royster-211 Midland Ave</b>			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Virus Infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Debility</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4800</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>2-17, 1968</b> , to <b>2-19, 1968</b> , that (I) (we) last saw the deceased alive on <b>2-17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Jerry C. Luck</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-19-68</b>								
22d. PHYSICIAN'S NAME (Type) <b>Jerry C. Luck</b>			22e. ADDRESS <b>427 Swale Road</b>														
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>			23b. DATE <b>2-21-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore City</b>								
24. FUNERAL DIRECTOR <b>W. Brown &amp; Son</b>			ADDRESS <b>100 W. Montgomery St.</b>			25a. REC'D BY REGISTRAR <b>FEB 21 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02043

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02031

1. DECEASED-NAME (Type or Print) <b>GARY</b>			First Middle Last <b>Lee Miller</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>2</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>A</b> M				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/8/50</b>		6. AGE (In years last birthday) <b>18</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>A. A. CO</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NORTH ARUNDEL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>				13b. COUNTY <b>A. A. Beach</b>				13c. CITY OR TOWN <b>Orchard XXXXXXXX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8228 Ft. Smallwood Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Paul C. Miller</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Marion E. Harp</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>Mrs. Marion E. Lawson 8228 Ft. Smallwood Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun that wound abdomen</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN'S</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976X</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>2/9 19 68</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Self Inflicted gunshot wound, abdomen</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>at beach</b>				21f. LOCATION Street or R.F.D. No. <b>Orchard Beach</b>		City or Town <b>AACO</b>		State <b>MD</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>E. H. H. H.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>2-9-68</b>					
EXAMINER'S NAME (Type) <b>E. H. H. H.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>2/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>McCully F. H.</b>				ADDRESS <b>237 Patapsco Ave. 21225</b>				25a. REC'D BY REGISTRAR <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

02044				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02032							
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR			
NELLIE				BUSS				Miller				Feb. Month Day 22 Year 68		M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost day) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
FE Male		White		25 Oct. 1903				84							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Pennsy.		U.S.				Anne Arundel									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie				W. Arundel				Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				A.A. Co.		Glen Burnie				7928 Oakwood Road					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
William W. Shaffer				Mary Buss											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
NO				166-20-3967		Mr. Sanders - Williamsport, Pa.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>												3 days			
470X DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <u>Pulmonary edema</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>Influenza</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
481X															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1968, to Feb. 22, 1968, that (I) (we) last saw the deceased alive on Feb. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
Robert Dabolin DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												2-23-68			
22d. PHYSICIAN'S NAME (Type) Robert Dabolin M.D.												22e. ADDRESS 400 Chain House Tr. St. G.R.B.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				26 Feb. 68		Wildwood Cemetery				Williamsport, Pa.					
24. FUNERAL DIRECTOR Robert Ware ADDRESS Singleton Funeral Home/Glen Burnie, Md.												25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
02045					02033							
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR		
John Arthur Minor					Feb 1 Day 68 Year					6:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		Negro		Dec 5, 1883			84 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Virginia		U.S.				Anne Arundel Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Lothian			Bayard Road			Cook & maintenance			Private Homes			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md			Anne Arundel		Lothian				Rural, Bayard Road			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
Samuel D. Minor				Evelina Woodford Minor Clark								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
				225-10-4404		Charles Minor, son, Lothian, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 Cerebral Vascular Accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease										2 years		
(c)										years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
443X None												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
				No injury								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 1/25/68 19, to 2/1/68 19, that (I) (we) last saw the deceased alive on 1/31/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE				22c. DATE SIGNED								
Charles H. Wirth MD				2/1/68								
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
Charles H. Wirth, MD				Lothian, Md 20820								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Removal		2-7-68		Woodlawn		Washington				DC		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
William Woodford		1622-11th St NW		DATE FEB 5 1968		Charles Judge						

03030

REPUBLIC OF CHINA

03030

03

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02046

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02034

1. DECEASED-NAME (Type or Print) <i>Clyde</i>			First Middle Last <i>MOORE</i>			2a. DATE KNOWN OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1968</i>			2b. HOUR <i>A</i> M			
3. SEX <i>M</i>		4. RACE <i>N</i>		5. DATE OF BIRTH <i>6-27-05</i>		6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>A. A. CO</i>			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA-NORTH ARUNDEL</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>227 Cherry Lane</i>		
14. FATHER'S NAME <i>John</i>				First Middle Last <i>moore</i>		15. MOTHER'S MAIDEN NAME <i>Esther Williams</i>				First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>20</i>		17. INFORMANT <i>Bessie Moore</i>				ADDRESS <i>Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Under</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4500</i>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State <i>AACO MD</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>E. L. H. R. L.</i>				EXAMINER'S NAME (Type) <i>E. L. H. R. L.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2/23/68</i>	
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
								ADDRESS (Street, city, town, or county) <i>AACO</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-26-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. Auburn</i>			23d. LOCATION (City or Town) (County) (State) <i>Balti. Md.</i>				
24. FUNERAL DIRECTOR <i>St. Mary's O. Wilson</i>				ADDRESS <i>1000 B. B. B. B.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 27 1968</i>			25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			

02050

1992

Figure 1

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02047

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02035

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Raymond Lester Morse						Feb. 29, 1968			p M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
Male		White		Aug. 1, 1897		70 YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH			
Yonkers, N. Y.			USA			WIDOWED			DIVORCED			Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Linthicum			107 S. Orchard Road			Machine Tool Designer			Universal						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Md.			AA			Linthicum			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			107 S. Orchard Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			
William A. Mor se			Jesse Kingman			No						Mrs. Edna W. Morse, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>7221</u>									YES <input type="checkbox"/> NO <input type="checkbox"/>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
CAUSE OF DEATH			HOUR A.M. P.M.												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED			
<u>Elmer Linhardt</u>			Elmer Linhardt, M. D.			<input type="checkbox"/>			<input type="checkbox"/>			2/29/68			
												AA Ed.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)			
Cremation			4 March 68			Loudon Park			Baltimore			Maryland			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Kirkley Funeral Home, Glen Burnie, Md.			MAR 4 1968			Charles Judge									

0200

0200

0200





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First JOHN		Middle J		Last MURRY		2a. DATE OF DEATH Month Day Year FEBRUARY 4 1968		2b. HOUR 8 a. M	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH OCTOBER 4, 1946			6. AGE (In years lost birthday) 21 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ottawa, Illinois			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Ft Geo G. Meade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier			12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Illinois			13b. COUNTY Cook			13c. CITY OR TOWN Evanston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1306 Oak Street	
14. FATHER'S NAME First Middle Last John A. Murry			15. MOTHER'S MAIDEN NAME First Middle Last Mary Alice O'Donnell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. 31Mar66-Feb68 306-46-5892			17. INFORMANT Hqs Sp Trps, Ft Geo G. Meade, Md 20755			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Acute Subdural hematoma's</u> DUE TO, OR AS A CONSEQUENCE OF <u>Rupture of dura covering atlanto-occipital space posteriorly, multiple facial lacerations. Fx of Rt Clavical</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 8 PM Feb 4 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Patient driving car, when it went off road						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Reese Road			21f. LOCATION Street or R.F.D. No. City or Town County State Reese Road, Fort Geo G. Meade, Md 20755						
22a. I certify that (1) this hospital attended the deceased from <u>WAS DOA</u> , <u>TX</u> , <u>TH</u> <u>4 Feb</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Theodore F. Toulam</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>Feb 6 1968</u>			
22d. PHYSICIAN'S NAME (Type) THEODORE F. TOULAM, CPT, MC						22e. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD 20755						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 6, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Columbus			23d. LOCATION (City or Town) (County) (State) Ottawa, Illinois				
24. FUNERAL DIRECTOR <u>Harry H. Willets</u>						ADDRESS Ellicott City Md.			25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

22950

10

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02049

02037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena.</i>				c. LENGTH OF STAY IN 1b <i>14 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none</i>				d. STREET ADDRESS <i>RFD 4 Box 365 Brunswick Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>William</i> Last <i>Myers, Sr.</i>				4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1968</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 7, 1901</i>		9. AGE (In years last birthday) <i>66</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Motorman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Transit Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Howard County</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Andrew Myers</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Miller</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>215-09-3873</i>		17. INFORMANT Address <i>Mrs. John Myers Pasadena, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung with metastases</i> <i>1621</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>163X</i> <i>none</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>January 9, 1968</i> to <i>February 2, 1968</i> , that (I) (we) lost the deceased alive on <i>February 1, 1968</i> , and that death occurred at <i>10 A</i> M, from causes and on the date stated above.									
22a. SIGNATURE <i>R.M. McLaughlin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>2/2/68</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>				22d. ADDRESS <i>3708 Mountain Road, Pasadena, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>G. Truman Schwab</i>				ADDRESS <i>3512 Frederick Ave. Balto. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02037

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02050

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02038

1. DECEASED NAME (Type or Print) <b>STEPHEN</b>			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year <b>2 28 1968</b>			2b. HOUR Minute <b>04</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 2, 1928</b>		6. AGE (in years last birthday) <b>39</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>Feb. 28 1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.						
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Pilot</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Air Line</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>115 Southway, Severna Pk.</b>		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT ADDRESS <b>Usual Negroescu - Above</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of the abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION <b>984 x</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>2:00 x 2 28 68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Subject in fight with A.A. Co. Police and was shot</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>115 Southway, Severna Pk. A. A. Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Edw F. Wilson</b>			EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>February 28, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clinton</b>			23d. LOCATION (City or Town) (County) (State) <b>Clinton N.J.</b>				
24. FUNERAL DIRECTOR <b>Robert S. Barranco</b>			ADDRESS <b>Severna Pk. Md.</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 4 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02051

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1. DECEASED-NAME (Type or print) <b>Carrie Josephine NUTWELL</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>2:15 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>JAN 19, 1887</b>		6. AGE (In years last birthday) <b>81</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>AA Co</b>	
10. CITY OR TOWN OF DEATH <b>Galesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>main st</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Galesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>main st</b>		14. FATHER'S NAME First Middle Last <b>William Albert Woodfield</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida BARBARA Sherbert</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>218-36-7634</b>		17. INFORMANT <b>MARIAN NUTWELL</b>		Address <b>Galesville, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gen. carcinomatosis</b> <b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ca of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>1 yr</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>July</b> , 19 <b>40</b> , to <b>Feb.</b> , 19 <b>68</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>2/25/1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
22b. SIGNATURE <b>S. Borssuck MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/27/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>S. Borssuck, M.D.,</b>				22e. ADDRESS <b>Amos Garrett Blvd., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Quaker</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville AA MD</b>	
24. FUNERAL DIRECTOR <b>Hardesty Funeral Home, Galesville, Md</b>				25a. REC'D BY REGISTRAR DATE <b>APR 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10-11-1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print) <b>Hans</b>			First <b>G.</b>			Middle <b>Olsen</b>			Last			2a. DATE OF DEATH 2 Month 25 Day 1968 Year			2b. HOUR A 3:54M		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>9/16/91</b>			6. AGE (In years lost-birth day) <b>75</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Norway</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>cook</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>A.A.Co.</b>			13c. CITY OR TOWN <b>Glen Burnie</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Rt. #2 Box 228</b>					
14. FATHER'S NAME First <b>Unk</b>			Middle			Last			15. MOTHER'S MAIDEN NAME First <b>Unk</b>			Middle			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Family</b>			Address <b>Same</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of bladder</b> 188X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with generalized metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1810												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/66</b> , to <b>2/25/68</b> , that (I) (we) last saw the deceased alive on <b>2/24/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Edmond I. Moushabeck</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2/25/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>EDMOND I. MOUSHABEK</b>			22e. ADDRESS <b>Glen Burnie, Md</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/28/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie AA Co Md</b>								
24. FUNERAL DIRECTOR <b>Mc Cully F.H. 237 Latopio ave</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>FEB 27 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02040

1. DECEASED-NAME (Type or Print) <i>Joseph F Padgett</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>18</i> Year <i>1968</i>			2b. HOUR <i>A</i> M		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Aug. 8, 1899</i>	6. AGE (in years last birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>18</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A. Co</i> Md.		
10. CITY OR TOWN OF DEATH <i>Fair Haven</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Postmaster</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>			13b. CITY OR TOWN <i>Fair Haven</i>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <i>George A.</i> Middle <i>Padgett</i> Last <i>George A. Padgett</i>			15. MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i>Trappe</i> Last <i>Catherine Trappe</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Postal</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>578-05-2245</i>			17. INFORMANT ADDRESS <i>Mrs. Mary Kirker Fair Haven, Maryland</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>955x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>976x</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Stroke</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>2/18 19 68</i> HOUR A.M. <i>4</i> P.M. <i>00</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Superficial punctured wound</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>			21f. LOCATION Street or R.F.D. No. <i>Fair Haven</i> City or Town <i>A.A. Co</i> County <i>A.A. Co</i> State <i>MD</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2/18/68</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Feb. 21, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>		
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>			ADDRESS <i>Owings, Maryland</i>			25a. REC'D BY REGISTRAR <i>FEB 21 1968</i>		
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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RECEIVED - DEPARTMENT OF THE ARMY

TO: THE SECRETARY OF THE ARMY  
FROM: THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or official communication.]

02800

02003

RECEIVED - DEPARTMENT OF THE ARMY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Robert Forest PARHAM</b>			First <b>Robert</b> Middle <b>Forest</b> Last <b>PARHAM</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>25</b> Year <b>68</b>			2b. HOUR M
3. SEX <b>M</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>10-11-25</b>		6. AGE (In years last birthday) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.			
10. CITY OR TOWN OF DEATH <b>Crownsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Crownsville State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto City Balto.</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>18 E LAFAYETTE, BALTO</b>
14. FATHER'S NAME First <b>Charles</b> Middle <b>PARHAM</b> Last <b>PARHAM</b>			15. MOTHER'S MAIDEN NAME First <b>ROSA</b> Middle <b>ODOH</b> Last <b>(PARHAM)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>212-24-9315</b>		17. INFORMANT <b>BUNA HAMILTON</b>		Address <b>18 E. LAFAYETTE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia, septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>gram negative bacteria?</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>carcinoma of lung?</b> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1638</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>on wk</b> <b>one wk</b> <b>years?</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>alcoholism, old polio</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. BENEDICT M.D.</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/25/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22e. ADDRESS <b>Crownsville State Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE <b>2/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		ADDRESS <b>1217 St. Paul St. Balto., Md. 21202</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02055		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02042	
Parker, Rachel		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)	First Middle Last	2a. DATE OF DEATH		2b. HOUR	
Rachel	Parker	Feb Month 18 Day 68 Year		653 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female	Colored	5-15-87		80 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland	U.S.A.			Anne Arundel Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie - md	Plaza Manor Convalescent	domestic		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Annapolis - md	A.A. Co	Annapolis		1001 Smithville St	
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last				
John Wesley Parker	Sarah West				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address			
no	218-12-1924	Mrs Giglio P.H.N.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Thrombophlebitis DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular Hypertensive Heartdisease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hrs Second day Unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 473X					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 10-12, 1967, to 2-18, 1968, that (I) (we) last saw the deceased alive on 2-16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard H. Hunt			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) Richard H. Hunt			22e. ADDRESS 1001 Chumley Glen Burnie, md		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
Burial	2-22-1968	John Wesley	Annapolis Md		
24. FUNERAL DIRECTOR William Reese			25a. REC'D BY REGISTRAR DATE FEB 20 1968		25b. REGISTRAR'S SIGNATURE Richard J. Jones

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12-1-62  
12-1-62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Muriel			Y. Peters			Feb. 29 1968			5:20 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	Negro		1-26-36			32 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
A.A. Co Md.		U.S.A.				A.A. Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel Hospital			Teacher		School	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			A.A.		Glen Burnie		YES		P.O. Box 345 21061
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
KENNETH FISHER			PICOLIA V. CEPHAS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No.					Rev. Wm. Peters		Box 292 Solly Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> , 19 <u>68</u> , to <u>2/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Guillermo S. Linsao, M.D.</u>					22c. DATE SIGNED <u>3/1/68</u>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Guillermo S. Linsao, M.D.					7308 Furnace Branch Road, Glen Burnie, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-4-68		Balto. Nat'l Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MORTON & DYETT F.H. 1701 Laurens Street					MAR 4 1968		<u>Charles Jones</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>7 mo 18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>L.</u> Last <u>Placide</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>19 68</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Walsh's Bakery</u>	9. AGE (In years last birthday) Yrs. <u>59</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Unknown George Doehring</u>		14. MOTHER'S MAIDEN NAME <u>Anna Gilman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Annette Rhodes, Dght., above</u> <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Consolidation</u> 3 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Viral pneumonia, Bilateral</u> 1 week DUE TO (c) <u>Malnutrition</u> month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492x None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no injury</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Did not attend</u> 19__ to __, 19__, that (I) (we) last saw the deceased alive on <u>2/22</u> 19 <u>68</u> , and that death occurred at <u>9:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Daugherty MD</u>		22b. DATE SIGNED <u>2/22/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Daugherty MD</u>		22d. ADDRESS <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/26/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schumanek</u>		25a. REC'D BY REGISTRAR <u>3331 BREHMS</u> <u>LANE</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. DATE <u>FEB 26 1968</u> <u>21213</u>	

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CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Place of Birth	
Occupation		Usual Residence	
Cause of Death		Date of Death	
Place of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner	

San Antonio, Tex.

San Antonio Cemetery

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San Antonio

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02058		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02045	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M
Lee Leroy R. Reid					2 8 68		6 P
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Male	Negro	2/28/95			72 YRS.	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Unknown	USA			Anne Arundel Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Crownsville	Crownsville State Hosp.			Retired		None	
13a. USUAL RESIDENCE (Where deceased admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Not known	Not known	Not known	YES <input type="checkbox"/> NO <input type="checkbox"/>	2118 N. Mulberry Street Balt			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Leroy			Reid	Rosa			Reid
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.		17. INFORMANT				
Unknown	Unknown		Hospital Records, Crownsville Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, G U tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardio vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Uremia; Chronic brain syndrome</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (H) (this hospital) attended the deceased from 11/4, 1967, to 1/8, 1968, that (I) (we) last saw the deceased alive on 1/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED	
L. Benedict, M.D.						1/9/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
L. Benedict, M.D.		Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	2/12/68	Baltimore National		Baltimore City			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
J. Brown		108 W. Montgomery		DATE FEB 13 1968	J. Charles Judge		

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02059  
Item 6 Film G398 2/28/68 kc

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02046

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR PM		
			William	Edward	REILLY	February 9, 1968			8:15		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
male		white		9/7/1899		68 69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Baltimore		U.S.A.				Anne Arundel					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis, Md.			Anne Arundel Gen. Hosp.			Ship Runner-checker			Heard		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Box 197A, Manhattan Beach, Severna Park			67			Md.					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
			Wm. E. Reilly, Sr.						Mary Knouse		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			4328 Plainfield Ave. 21206 Gloria Buchheister, dght.		
			213-07-9455								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>or Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Arrest</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Benign Prostatic Hypertrophy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2-8-68		BPH		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 30, 1968</u> , to <u>Feb. 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		MD DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		T. G. Osius, M. D.		22e. ADDRESS		77 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/13/68		Glen Haven Mem. Park		Baltimore, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Schimunek Funeral Home, Inc.		3331 Brehms Lane		DATE FEB 20 1968		[Signature]					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Santa</b>			First Middle Last			2a. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>1968</b>		2b. HOUR <b>6:10</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-1-88</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Outing Ave. &amp; 207th St.</b>	
14. FATHER'S NAME <b>Louis Caravanti</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Mary ---</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-14-5977</b>		17. INFORMANT <b>Patients Chart</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pancreatitis</b> <b>5770</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5770</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes, Arteriosclerotic Heart Disease</b>									
19a. DATE OF OPERATION <b>2-10-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pancreatitis</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 19 <b>68</b> , to <b>2-11</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>2-11-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John J. Tolentino</b>		MD DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-11-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Tolentino</b>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-14-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hgwy., A.A.Co., Md.</b>			
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02061												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												02048											
1. DECEASED-NAME (Type or print)												20. DATE OF DEATH												2b. HOUR											
First Middle Last												Month Day Year												A. M.											
Mary Elizabeth ROSATI												February 4 1968												6:30 M											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.															
F				W				3-30-1903				64 YRS				MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
MD.				U.S.								Anne Arundel Md.																							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																							
ANNAPOLIS				A.A. GENERAL				HOME WIFE				HOME																							
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER																			
MD.				A.A.				ANNAPOLIS				YES				314 TAYLOR AVE.																			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																															
First Middle Last				First Middle Last																															
Joseph BARRY				Bertrude BARK																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not of unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address																							
NO								NICHOLAS T. ROSATI				#13																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) Cerebral Thrombosis												30 MINUTES																							
433.9 DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332.7																																			
(b) Arteriosclerosis Generalized												10 YEARS																							
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
ARTERIOSCLEROTIC HEART DISEASE, DIABETES MELLITUS																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (the hospital) attended the deceased from 10 JAN, 1968, to 4 FEB, 1968, that (I) (we) last saw the deceased alive on 4 FEB, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE												22c. DATE SIGNED																							
Edward S. Beck, M.D.												5 Feb 68																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
Edward S. Beck, M.D.												73 Franklin St., Annapolis, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																							
BURIAL				2-6-68				ST. MARYS				ANNAPOLIS A.A. MD.																							
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
John M. Lyons Sons Annapolis, Md.												FEB 7 1968																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

02062										02049									
Item 6 Film G398 3/6/68 ap										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH									
First Middle Last										Month Day Year									
Lois Martin SAPP										February 21 1968									
3. SEX										4. RACE									
Female										White									
5. DATE OF BIRTH										6. AGE (In years last birthday)									
Dec. 5, 1910										77 YRS.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?									
Texas										USA									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH									
										Anne Arundel Md.									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)									
Annapolis										AA General									
12a. USUAL OCCUPATION (Kind of work done during most of working life, except retired.)										12b. KIND OF BUSINESS OR INDUSTRY									
TELEPHONE OPER.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY									
MD.										AA CO. CHURCHTON									
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last									
CHARLES BAGLEY MARTIN										ANNA SHEAR									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO.									
										262-32-6109									
17. INFORMANT										Address									
MARCUS D. SAPP										CHURCHTON, Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a)										36 hours									
481X acute renal failure (lower nephron section)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b) Bilateral lobar pneumonia										3 weeks									
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
490 X Chronic nephrosclerosis, gout, hypertension																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Jan 61, to Feb 21, 1968, that (I) (we) last saw the deceased alive on Feb 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										22c. DATE SIGNED									
Willard F. Smith										2/22/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS									
Willard F. Smith, M.D.										Shady Side, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE									
Burial										Feb 26, 1968									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Baltimore National										Baltimore Md									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR									
Hardesty Funeral Home, Gaithersburg, Md										DATE MAR 1 1968									
										25b. REGISTRAR'S SIGNATURE									
										Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
FREDERICK			G. SAWYER			FEB Month 16 Day 1968		6:20 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
MALE		WHITE		SEPT 9, 1903		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MASS.		USA				ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
FT GEO G MEADE, Md.			KIMBROUGH ARMY HOSPITAL			Retired Serviceman		U.S. Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Laurel				806 Kay Court		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Walter Sawyer			Alma Haines						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
yes			1929-1957		Marion Sawyer, (same as 13 a & 13 e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									3 weeks
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic Heart Disease</u>									30 yrs
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None		None		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (H) (this hospital) attended the deceased from <u>24 Jan</u> , 19 <u>68</u> , to <u>16 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>16 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
John J. Rothchild, M.D.								16 Feb 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
JOHN J. ROTHCHILD, CPT, MC,				KIMBROUGH ARMY HOSP, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 20, 1968		Arlington National		Arlington, Va.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Be Witt Donaldson, Laurel, Md				DATE FEB 23 1968		Charles Judge			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>02064</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02051</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or print) <b>SUSIE T. SCHEEL</b>						2a. DATE OF DEATH <b>February</b> Month <b>4</b> Day <b>1968</b> Year			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 28, 1871</b>			6. AGE (In years lost birthday) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Linthicum</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>304 E. Maple Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>304 E. Maple Road</b>			
14. FATHER'S NAME First <b>Peter</b> Middle <b>Reinig</b> Last				15. MOTHER'S MAIDEN NAME First <b>Barbara</b> Middle <b>Bierner</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Kutztown</b> <b>Mr. Orville H. Scheel, 48 S. Laurel, Pa.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b> <b>10-15 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/4/68</b> , 19 <b>68</b> , to <b>2/4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/4/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Chas. L. Ball Jr. M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <b>2/4/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles L. Ball, Jr.</b>		22e. ADDRESS <b>203 W. Maple Rd., Linthicum, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-7-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>						25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tobacco papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>02065</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02052</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>												
1. DECEASED-NAME (Type or print) <b>Margaret</b>						First <b>H.</b>		Middle <b>Schwarzwaelder</b>		Last		
2a. DATE OF DEATH <b>2/19/68</b>						Month <b>2</b> Day <b>19</b> Year <b>68</b>		2b. HOUR <b>M</b>				
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Oct. 22, 1898</b>			6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>A A County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Gibson Island</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>				13b. COUNTY <b>AA County</b>		13c. CITY OR TOWN <b>Gibson Island</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>Gibson Island, Md.</b>		
14. FATHER'S NAME <b>Charles</b>				First <b>Edward</b>		Middle <b>Holbein</b>		15. MOTHER'S MAIDEN NAME <b>Elizabeth Rachel Jones</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. <b>238-48-2584 B</b>		17. INFORMANT <b>Mr. Christian Schwarzwaelder same address</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL HYPOXIA</b>											<b>ACUTE</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>472X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)											<b>CHRONIC</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>5277</b>												
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY <b>19</b> HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 19</b> , 19 <b>68</b> , to <b>FEB 19</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) lost the deceased alive on <b>FEB 19</b> , 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.												
22b. SIGNATURE <b>G. Schmeisser MD</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/20/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>GERHARD SCHMEISSER JR MD</b>						22e. ADDRESS <b>SKYWATER RD, GIBSON ISLAND, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>			23d. LOCATION (City or Town) <b>Arlington, Va.</b>		(County) (State)		
24. FUNERAL DIRECTOR <b>Wmf. Tickner + Sons</b>						ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		

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# MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02066

02053

1. DECEASED-NAME (Type or print) <b>Agnes M. Seidler</b>			20. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>68</b>			2b. HOUR <b>6 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>14 Dec. 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel County</b> Md.	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hosp. Clerk</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dept. Store</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Thomas F. Polley Sr.</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Agnes Schultz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-40-9178</b>		17. INFORMANT Address <b>Mr. C. Melvin Seidler (Husband) Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of sigmoid</b> <b>1533</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases to abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>probable metastatic brain</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5-6 mo</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1533</b> <b>aspiration</b>							
19a. DATE OF OPERATION <b>Dec 66</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of sigmoid</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>3-19-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Alvarez</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>2-21-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>S. Alvarez</b>		22e. ADDRESS <b>North Arundel Medical Bldg Glen Burnie, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Maryland</b>	
24. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

MEDICAL CERTIFICATION

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Handwritten notes and markings on the right margin, including a large vertical scribble and two punch holes.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
02067		02054									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>						d. STREET ADDRESS <u>352 Earleigh Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Smith</u> First Middle Last						4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1968</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 19, 1968</u>		9. AGE (In years last birthday) yrs. <u>40</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - A.A. Co.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick James Smith</u>						14. MOTHER'S MAIDEN NAME <u>Arlene Thelma Anderson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Frederick J. Smith (Father)</u>		Address <u>Same as # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u> <u>7762</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7735</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2/19/</u> , 19 <u>68</u> , to <u>2/22/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/21/</u> 19 <u>68</u> , and that death occurred at <u>3<sup>30</sup></u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Allen Y. Wolins</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/22/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Wolins</u>						22d. ADDRESS <u>325 Hospital Dr. Medical Arts Bldg.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/23/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>					
24. FUNERAL DIRECTOR <u>Robert P. Ware</u>						ADDRESS <u>Singleton Funeral Home/Glen Burnie, Md</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Elizabeth				(M)		SMITH		February		9:28A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Nov. 14, 1888		79		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
England		USA				Anne Arundel					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General		Housewife							
13a. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER					
Maryland		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		31 Goodrich Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
John		Kathleen		No				Mrs. G. Keith Witheridge		#13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109				Acute myocardial infarction						36 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Acute biliary obstruction (stones) and						48 hrs.	
				(c) Severe coronary artery sclerosis.						10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4201		Diabetes mellitus.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July, 1957, to Feb, 1968, that (I) (we) last saw the deceased alive on Feb 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
		John Hedeman M.D.		2/2/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE							
JOHN HEDEMAN		Forest Dr. Annapolis Md.		FEB 6 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. (County)		23f. (State)	
Burial		2-5-1968		Memorial Shrine		Corverton		Pa.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John M. Taylor & Son		Annapolis, Md.		FEB 6 1968		Charles Judge					

02280

02062

DATE: 10/10/50 TIME: 10:00 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>02069</div> <div> <div>16</div> <div>1</div> </div> <div> <div>02054</div> <div>1</div> </div>											
<div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div> <div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> </div> <div> <div>15</div> <div>16</div> </div> <div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> </div> <div> <div>21</div> <div>22</div> </div> <div> <div>23</div> <div>24</div> </div> <div> <div>25</div> <div>26</div> </div> <div> <div>27</div> <div>28</div> </div> <div> <div>29</div> <div>30</div> </div> <div> <div>31</div> <div>32</div> </div> <div> <div>33</div> <div>34</div> </div> <div> <div>35</div> <div>36</div> </div> <div> <div>37</div> <div>38</div> </div> <div> <div>39</div> <div>40</div> </div> <div> <div>41</div> <div>42</div> </div> <div> <div>43</div> <div>44</div> </div> <div> <div>45</div> <div>46</div> </div> <div> <div>47</div> <div>48</div> </div> <div> <div>49</div> <div>50</div> </div> <div> <div>51</div> <div>52</div> </div> <div> <div>53</div> <div>54</div> </div> <div> <div>55</div> <div>56</div> </div> <div> <div>57</div> <div>58</div> </div> <div> <div>59</div> <div>60</div> </div> <div> <div>61</div> <div>62</div> </div> <div> <div>63</div> <div>64</div> </div> <div> <div>65</div> <div>66</div> </div> <div> <div>67</div> <div>68</div> </div> <div> <div>69</div> <div>70</div> </div> <div> <div>71</div> <div>72</div> </div> <div> <div>73</div> <div>74</div> </div> <div> <div>75</div> <div>76</div> </div> <div> <div>77</div> <div>78</div> </div> <div> <div>79</div> <div>80</div> </div> <div> <div>81</div> <div>82</div> </div> <div> <div>83</div> <div>84</div> </div> <div> <div>85</div> <div>86</div> </div> <div> <div>87</div> <div>88</div> </div> <div> <div>89</div> <div>90</div> </div> <div> <div>91</div> <div>92</div> </div> <div> <div>93</div> <div>94</div> </div> <div> <div>95</div> <div>96</div> </div> <div> <div>97</div> <div>98</div> </div> <div> <div>99</div> <div>100</div> </div>											

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02070

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02057

1. DECEASED-NAME (Type or Print) <i>George E. Smith</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>25</i> Year <i>1968</i>			2b. HOUR <i>P</i> M	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>4-11-89</i>	6. AGE (in years last birthday) <i>78</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>25</i> Year <i>1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>AA County</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A. A. CO</i>	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.D.A.-NORTH-ARNOEL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Steel Corp.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>107 Greenway, Marley Park</i>		14. FATHER'S NAME First <i>George</i> Middle <i>Smith</i> Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>Florence</i> Middle <i>Preston</i> Last <i>Preston</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>4409</i>		17. INFORMANT <i>Mrs. Bertha F. Smith, same as 13</i>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis generalized</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4500</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ADDRESS (Street, city, town, or county) <i>A.A. CO.</i>		22b. DATE SIGNED <i>2/25/68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>28 Feb. 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md. 21225</i>	
24. FUNERAL DIRECTOR <i>Kirkley Funeral Home, Glen Burnie, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>FEB 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

HEALTH 2551

08523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03010

DEPARTMENT OF HEALTH  
STATE OF NEW YORK

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>02071</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02658</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or print) <b>Geo. Riggs</b> <b>Smith</b>						2a. DATE OF DEATH <b>2-22-68</b>			2b. HOUR <b>7:05 PM</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>1-15-09 1911</b>			6. AGE (In years last birthday) <b>56 27</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 8 Box 298</b>		
14. FATHER'S NAME First <b>Charles T</b> Middle <b>T</b> Last <b>T</b>						15. MOTHER'S MAIDEN NAME First <b>R. 928</b> Middle <b>R</b> Last <b>R</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NE</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>224-07-8275</b>		17. INFORMANT <b>Family - Same</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Intracerebral Hemorrhage</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs</b> <b>2-3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-22-68</b> , 19 <b>68</b> , to <b>2-22-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-22-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. H. T. O'Herlihy</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>2-22-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. H. T. O'Herlihy, MD</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		23d. LOCATION (City or Town) <b>Baltimore</b> (County) (State)					
24. FUNERAL DIRECTOR <b>McCully - 130 E Fort Ave</b> ADDRESS						25a. REC'D BY REGISTRAR <b>FEB 26 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02072

02059

1. DECEASED-NAME (Type or print) <b>William</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>FEB.</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>10:30 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 2<sup>nd</sup> 1886</b>				6. AGE (In years lost birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ANNE ARUNDEL Co.</b> Md.						
10. CITY OR TOWN OF DEATH <b>Crownsville, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Crownsville State Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>WATCHMAN (R-T)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Corp</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>3554 HELMSTETTER</b>				
14. FATHER'S NAME First <b>JOHN</b> Middle <b>SMITH</b> Last <b>SMITH</b>		15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>None</b>		16b. SOCIAL SECURITY NO. <b>217-07-1118</b>		17. INFORMANT <b>MRS Nettie E. Seemans</b>		Address <b>11475 AVE SEVERN, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>bacteria?, uremia, senility.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>anemia, hemorrhoid.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one wk</b> <b>long standing</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>peptic ulcer (history of) gastrectomy, chronic brain syndrome due to cerebral A.S.</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from <b>12/18/67</b> , 19__, to <b>2/10/68</b> , 19__, that (I) (we) last saw the deceased alive on <b>2/10/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>L. BENEDICT MD.</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/11/68</b>						
22d. PHYSICIAN'S NAME (Type)		<b>L. BENEDICT MD.</b>		22e. ADDRESS <b>Crownsville State Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Feb. 14, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR <b>E.B. Fleming</b>		ADDRESS <b>Singleton Funeral Home Glen Burnie, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

MEDICAL CERTIFICATION

05052

RECEIVED OF CASH

05052

1914

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02073

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02050

1. DECEASED-NAME (Type or Print) <i>Esther</i>		Middle <i>SOMERVILLE</i>		Last <i>SOMERVILLE</i>		2a. DATE KNOWN OF DEATH Month <i>2</i> Day <i>13</i> Year <i>68</i>		2b. HOUR <i>P</i> M	
3. SEX <i>F</i>	4. RACE <i>N</i>	5. DATE OF BIRTH <i>1-19-1964</i>	6. AGE (In years last birthday) <i>4</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>13</i> Year <i>68</i>		2d. HOUR <i>P</i> M	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A.Co</i> Md.			
10. CITY OR TOWN OF DEATH <i>Gen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Mark's Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>C.C. Somerset</i>		13c. CITY OR TOWN <i>Bat 200 Mc Kenney</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>Williss</i> Middle <i>Somerville</i> Last <i>Somerville</i>		15. MOTHER'S MAIDEN NAME First <i>Esther</i> Middle <i>Holmes</i> Last <i>Holmes</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Esther Holmes</i>				ADDRESS <i>Somerset, Park</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>890x</i> IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Choke</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>9160</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>2/13 19 68</i> HOUR A.M. <i>P.M.</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>House Fire</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>Aske</i>		City or Town <i>MD</i>		County <i>Aske</i> State <i>MD</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		22b. DATE SIGNED <i>2/13/68</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>		ADDRESS <i>Crinner</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>FEB 15 1968</i>	

05030

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05030

1

8891 61 534  
1988 10 19

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Judy				SOMERVILLE		SOMERVILLE		Month 2 Day 13 Year 1968		P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
F	N	12-19-1961		6 YRS.		MONTHS DAYS HOURS MIN.				Month 2 Day 13 Year 1968 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD		U.S.A.				A.A.CO Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Johns Hopkins		D.H. Marsh Building									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD		A.A. Severn		A.A. Severn				Batavia McKinsey Rd			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Willis		Somerville						Esther		Holmes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
				Esther Holmes		Severn Park					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd degree Burns 50% Total 890X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asphyxia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 9160										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2/13 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fire-House							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
						A.A.CO		MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 2/13/68 A.A.CO	
ACTUAL SIGNATURE E. Linhart		EXAMINER'S NAME (Type) E. Linhart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR DATE FEB 15 1968			
Burial 2-17-1968				Carpenter Hill		Round Bay MD		25b. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR William Beesett		ADDRESS A.A.CO									



02020

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02075				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH				02062							
1. DECEASED-NAME (Type or print)		First Marie		Middle (NONE)		Last STEPNEY		2a. DATE OF DEATH Month February		Day 15		Year 1968		2b. HOUR 6:25	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5/3/08		6. AGE (In years last birthday) 59		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. OAYS		HOURS		MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Anne Arundel								Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Calvert		13c. CITY OR TOWN Ches. Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
14. FATHER'S NAME First Samuel		Middle Harrie		Last Dennie		15. MOTHER'S MAIDEN NAME First Dennie		Middle Smith		Last Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT James Stepney		Address Chesapeake Beach Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of head of pineal about 1 year 157.9 DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X															
19a. DATE OF OPERATION 6/28/67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice due to #18		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from June, 1967, to 2/15/68, 1968, that (I) (we) last saw the deceased alive on 2/15/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Charles H. Wirth, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/15/68									
22d. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D.		22e. ADDRESS Lothien, Md 20820													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-18-68		23c. NAME OF CEMETERY OR CREMATORY St. Edmonds Ch. Cem		23d. LOCATION (City or Town) (County) (State) Sunderland Cal. Md.									
24. FUNERAL DIRECTOR Pinkney E. Sewell		ADDRESS Lanham Md		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									

02082

02082

02082

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 1968" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>William</i> First Middle Last <i>Stewart</i>			2a. DATE OF DEATH <i>Feb</i> Month <i>1</i> Day <i>68</i> Year			2b. HOUR <i>M</i>	
3. SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>July 4 1899</i>		6. AGE (In years last birthday) <i>68</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Newbern N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A. County Md.</i>	
10. CITY OR TOWN OF DEATH <i>Paradise Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Arundel Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Paradise Md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Md.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Post 9 Box 250</i>		14. FATHER'S NAME First Middle Last <i>Unknown</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-07-0759</i>		17. INFORMANT <i>Addie Stewart</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4-10-68</i> IMMEDIATE CAUSE (a) <i>DOA @ North Arundel Hosp.</i> <i>Prostacy</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Disease &amp; Angina</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10. Mar.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-8-68</i> , 19 <i>68</i> , to <i>Feb 1</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-22</i> 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>T.M. SHIPLEY MD</i> DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>2-6-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>T.M. SHIPLEY</i>				22e. ADDRESS <i>Baltimore Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 6, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. Auburn Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>Chroy D. Wilson</i> ADDRESS <i>1000 Brantley Ave.</i>				25a. REC'D BY REGISTRAR <i>FEB 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

40750

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02076						02063					
1. DECEASED-NAME (Type or print) <u>Margaret E. Stewart</u>						2a. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1968</u>			2b. HOUR <u>11</u> a <u>M</u>		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>15 Sept. 1911</u>		6. AGE (In years' last birthday) <u>56</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS. HOURS <u>  </u> MIN <u>  </u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Anne Arundel</u> Md.					
10. CITY OR TOWN OF DEATH <u>Glen Burnie</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>North Arundel Nursing Home</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>AA</u>		13c. CITY OR TOWN <u>Glen Burnie</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>15 Brownshade Drive</u>			
14. FATHER'S NAME First <u>Robert</u> Middle <u>Fletcher</u> Last <u>  </u>				15. MOTHER'S MAIDEN NAME First <u>Bessie</u> Middle <u>  </u> Last <u>Harley</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Jean Walters, same as 13</u>				Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1560</u> IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Gall Bladder</u> <u>Months</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1551</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u> P.M. <u>  </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 7, 1968</u> , to <u>2/17, 1968</u> , that (I) (we) lost saw the deceased alive on <u>2/16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ernesto A. Tolentino, M.D.</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>2/17/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Ernesto A. Tolentino, M.D.</u>						22e. ADDRESS <u>325 Hospital Drive, Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>20 Feb. 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park, Glen Burnie, Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>  </u> <u>  </u> <u>  </u>					
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u> ADDRESS <u>  </u>						25a. REC'D BY REGISTRAR <u>FEB 20 1968</u> DATE <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05888

CRIMINAL RECORD

05030

RECEIVED  
FEB 20 1963

FEB 20 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Helen</b>			First <b>T.</b> Middle <b>Stoll</b> Last			2a. DATE OF DEATH Feb. Month <b>3</b> Day <b>68</b> Year			2b. HOUR <b>9/20A</b> M
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>11-30-89</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>No. Arundel General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>267 Hammarlee Road</b>
14. FATHER'S NAME First <b>Henry J.</b> Middle <b>Schnuck</b> Last				15. MOTHER'S MAIDEN NAME First <b>Hilt</b> Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-09-4917B</b>		17. INFORMANT Address <b>Mr. Herman C. Stoll 267 Hammerlee Rd.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma abd. (carcinoma)</b> <b>183.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>prob. ovarian</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>month</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1750</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-68</b> , 19____, to____, 19____, that (I) (we) last saw the deceased alive on <b>2-3-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David L. Abramson</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>Feb. 5, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>David L. Abramson M.D.</b>				22e. ADDRESS <b>707 Old Annapolis Rd. N.E. Glen Burnie, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 6, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hwy. Balto.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03050

03050

03050



RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02079		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02066	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M
WILLIAM		ALEXANDER	SWANSTON	February 15 1968		2315	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 21 August 1896		6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. NAVY		12b. KIND OF BUSINESS OR INDUSTRY Capt. RET.	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last DONALD C. SWANSTON		15. MOTHER'S MAIDEN NAME First Middle Last MARGARET PATTERSON		13e. STREET AND NUMBER 710 Americana Drive, Apt. 54			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. 1916-1947		17. INFORMANT MARY J. SWANSTON		Address # 130	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INFARCTION, MYOCARDIUM</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4207							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10 January, 1968</u> , to <u>15 February 1968</u> , that (I) (we) last saw the deceased alive on <u>15 February 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>H. P. Arentzen</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 2/15/68	
22d. PHYSICIAN'S NAME (Type) W. P. ARENTZEN, CAPT MC USN		22e. ADDRESS Naval Hospital, Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-19-68		23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		23d. LOCATION (City or Town) (County) (State) Annapolis P.A. MD.	
24. FUNERAL DIRECTOR TAYLOR & SONS FUNERAL HOME		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE FEB 21 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
ROBERT N		TALBOTT						2 4 68		3:20 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
M	W		3/19/97			70 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD.		U.S.				ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS			ANNE ARUNDEL GENERAL HOSP.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			A.A.		CROFTSVILLE				AT, 2-BOX 435	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
?			?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES			WW2		717-07-8062 LENA V. TALBOTT (SAME)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma										24 hrs.
5718 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver, cause undetermined										8 mo.
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5810										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from June 1967, to 2/4, 1968, that (I) (we) last saw the deceased alive on 2/4 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										22c. DATE SIGNED
Richard N. Peeler M.D.										2/4/68
22d. PHYSICIAN'S NAME (Type) RICHARD N. PEELER					22e. ADDRESS ANNAPOLIS, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/8/68		WILKESBURG			BALTA CO			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Paul E. Charney					FEB 9 1968		James Judge			

03003

03003





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02081

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02068

1. DECEASED-NAME (Type or Print) <i>Jamies</i>			First Middle Last <i>Taylor</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>12</i> Year <i>1968</i>			2b. HOUR <i>M</i>		
3. SEX <i>M</i>		4. RACE <i>N</i>		5. DATE OF BIRTH <i>18 96</i>		6. AGE (in years last birthday) <i>71</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <i>AA Co</i> Md.		
10. CITY OR TOWN OF DEATH <i>Lodwick</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Labor</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MO</i>			13b. COUNTY <i>AA Co</i>			13c. CITY OR TOWN <i>Lodwick</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME First <i>Ned</i> Middle Last <i>Taylor</i>			15. MOTHER'S MAIDEN NAME First <i>Agnes</i> Middle Last <i>Reed</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>W.W.I</i>			16b. SOCIAL SECURITY NO. <i>214-127-303</i>			17. INFORMANT <i>Isiah Taylor</i>			ADDRESS <i>Dunkirk ; A.A. Co. Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerosis generalized</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4500</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Shubert</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2/12/68</i>		
EXAMINER'S NAME (Type) <i>E. L. Shubert</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>AA Co.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-17-68</i>			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY <i>Moses</i>			23d. LOCATION (City or Town) (County) (State) <i>AA Co. Md.</i>		
24. FUNERAL DIRECTOR <i>Linkway E. Sewell Prince Fred. Md.</i>						25a. REC'D BY REGISTRAR <i>FEB 14 1968</i>			25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 See birth cert. MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02082

CERTIFICATE OF DEATH

02069

1. DECEASED-NAME (Type or print)		First <b>Baby Girl</b>		Middle <b>Thomas</b>		Last <b>Thomas</b>		2a. DATE OF DEATH Month Day Year <b>February 20 1968</b>			2b. HOUR <b>1045A</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>February 20, 1968</b>			6. AGE (In years lost birthday) YRS. MONTHS DAYS <b>2 0 30</b>		IF UNDER 1 YEAR MONTHS DAYS <b>2 0</b>		IF UNDER 24 HRS. HOURS MIN <b>30</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.						
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>***</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1305 54th Ave. Apt. 301</b> <b>Naval Hospital</b>				
14. FATHER'S NAME First Middle Last <b>Alfred Ernest Thomas</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Justlin Jerome</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Annapolis, Md</b> <b>Jerome McGowan 106 Louis Drive</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IMMATURITY</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> , 19 <b>68</b> , to <b>2-20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>B. R. Fulk</b>		22c. DATE SIGNED <b>2-21-68</b>			22d. PHYSICIAN'S NAME (Type) <b>B. R. FULK, LT MC USN</b>							
22e. ADDRESS <b>NAVAL HOSPITAL, ANNAPOLIS, MD.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-23-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NAVAL CEMETERY</b>			23d. LOCATION (City or Town) <b>ANNAPOLIS A.A. Md.</b>		County		State	
24. FUNERAL DIRECTOR <b>Hicks Funeral Home, Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>							

28950

YTI 25T.KM

xx

828 ON T. J. M. J. J.

1971-1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02083										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02070																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										P M																																							
John Frank THOMAS										February 13 1968										6:15 M																																							
3. SEX M										4. RACE W										5. DATE OF BIRTH 3-30-1898										6. AGE (In years last birthday) 69 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MD										7b. CITIZEN OF WHAT COUNTRY? U.S.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.																													
10. CITY OR TOWN OF DEATH Annapolis										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.A. GENERAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BOAT BUILDING										12b. KIND OF BUSINESS OR INDUSTRY BOAT																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.										13b. COUNTY H.A.										13c. CITY OR TOWN St. Marys										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER RFD #5 Box 249																			
14. FATHER'S NAME First Middle Last William F. THOMAS										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth V. TAYMAN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO. -										17. INFORMANT Address SARAH F. THOMAS #13																			
MEDICAL CERTIFICATION										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 423X Uremia, pericarditis, distention DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension CVD & CHL 443X APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4+8																																																	
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arterial infarction Rt. Kidney Obstruction, BPH, Prostate																																																	
										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
										21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1-20-1968 to 2-13-1968, that (I) (we) lost soul the deceased alive on 2-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Frank M Shipley MD										22c. PHYSICIAN'S NAME (Type) F M SHIPLEY										22d. ADDRESS Annapolis, Md										22e. DATE SIGNED 2-15-68																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 2-16-68										23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN										23d. LOCATION (City or Town) (County) (State) GLEN BURNIE MD.																													
24. FUNERAL DIRECTOR John M. Lyons										24b. ADDRESS Annapolis, Md.										25a. REC'D BY REGISTRAR DATE FEB 16 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

03030

03030

3-30-1888

W

M

W.2

MD

Annabergis  
MD.  
William F. Thomas  
Sarah F. Thomas = 18  
Elizabeth V. TAYMAN  
A.H. Thomas  
A.H. Thomas  
Box 245  
Port Building  
Port

GRAND 8-18-18 Glen Haven  
John H. Thomas (Annaberg, Md.)  
Glen Haven  
MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MD. DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02084		02671	
1. DECEASED-NAME (Type or print) <b>BLANCHE BUSEY THOMSON</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>2</b> Year <b>68</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>7-8-1889</b>	6. AGE (In years last birthday) <b>78</b> YRS. IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ANNE ARUNDEL</b> Md.
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Annapolis Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>A.A. Co.</b>	13c. CITY OR TOWN <b>ANNAPOLIS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER <b>151 MONTICELLO AVE</b>
14. FATHER'S NAME First <b>DR. CHARLES</b> Middle <b>E.</b> Last <b>BUSEY</b>	15. MOTHER'S MAIDEN NAME First <b>ROSA</b> Middle <b>T.</b> Last <b>BELL</b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service) 16b. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>EARL W. THOMSON</b> Address <b># 130</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			<b>Several years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>3.31X</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec.</b> , 19 <b>65</b> , to <b>FEB</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>January</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Robert Brein M.D.</b> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>2/3/68</b>
22d. PHYSICIAN'S NAME (Type) <b>ROBERT BREIN M.D.</b>		22e. ADDRESS <b>121 Calhoun St. Annapolis Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2-5-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Hycoburg Va.</b>
24. FUNERAL DIRECTOR <b>John M. G. Loxton Annapolis, Md</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>

05051

RECEIVED IN DEPT

05050

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02085										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02072									
Itmes 7a & 7b 13a,c,& Film G398 2										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)			First <b>DENNIS</b>			Middle <b>ROBERT</b>			Last <b>TURNER</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1968</b>						2b. HOUR <b>M</b>											
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>21 August 1941</b>			6. AGE (In years last birthday) <b>26</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>														
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Anne Arundel</b> Md.																				
10. CITY OR TOWN OF DEATH <b>Annapolis, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PO1</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b> CITY <b>New Hampshire</b>			13b. COUNTY <b></b>			13c. CITY OR TOWN <b>Rochester</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Crown Point Road</b>																	
14. FATHER'S NAME First <b>Robert</b> Middle <b>Irving</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Mildred</b> Middle <b>Mac</b> Last <b>Abee</b>																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>017 32 0067</b>			17. INFORMANT Address <b>U. S. Navy Records</b>																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>9109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>929.9</b>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>J. P. O'REILLY, LCDR MC USN</b>														22c. DATE SIGNED <b>2-13-68</b>															
22d. PHYSICIAN'S NAME (Type) <b>J. P. O'REILLY, LCDR MC USN</b>														22e. ADDRESS <b>NAVAL HOSPITAL, ANNAPOLIS, MD.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Feb. 13 '68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Howard Street</b>			23d. LOCATION (City or Town) (County) (State) <b>Northborough Mass</b>																				
24. FUNERAL DIRECTOR <b>Harry Witzke</b>			ADDRESS <b>Howard County Funeral Home, Ellicott City, Md.</b>			25a. REC'D BY REGISTRAR <b>FEB 16 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																				

02030

02030

RECEIVED  
JAN 11 1961  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

Yes

RE: [Illegible]

X

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02086										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02073																			
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR									
EVA										L.										WALLS										FEBRUARY 2 1968 1:30 P.M.									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.														
FEMALE					WHITE					FEB. 21-1888					79 YRS.					MONTHS					DAYS														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH										Md.														
MARYLAND					USA										ANNE ARUNDEL																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																								
BROOKLYN PARK					xx					HOUSEWIFE					xx																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																			
MARYLAND					ANNE ARUNDEL					BROOKLYN PARK										2-8TH. AVENUE																			
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																																		
CHARLES					LEAGER					JENNIE					BURGESS																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																													
No					216-18-2020					MRS. GRACE SCHWARZMAN - BROOKLYN PR.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Myocardial Infarction																																							
4109 DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																							
(b) DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
4201																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 1967, to 27 Feb 1968, that (I) (we) last saw the deceased alive on 31 Jan 68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED									
A. R. Sosnowski																														2/2/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
A. R. Sosnowski M.D.										4016 Ritchie Hwy Balto - 25-Md																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
BURIAL					FEB. 4					SUDLERSVILLE					SUDLERSVILLE MD.																								
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Edgar D. Kane										CHURCH HILL MD.										DATE FEB 7 1968										Charles Judge									

KT080

CHRONOLOGICAL DATA

05088

1. NAME: [illegible]  
2. DATE: [illegible]  
3. TIME: [illegible]  
4. LOCATION: [illegible]  
5. WEATHER: [illegible]  
6. COMMENTS: [illegible]  
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99. [illegible]  
100. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02087		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02074	
Items 23c & d Film G398 2/28/68 <b>CERTIFICATE OF DEATH</b>					
1. DECEASED-NAME (Type or print) First Middle Last <b>Helene Webber</b>			2a. DATE OF DEATH Month Day Year <b>February 12 1968</b>		2b. HOUR <b>6:00P</b>
3. SEX <b>Female</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH <b>14 March 1937</b>		6. AGE (In years last birthday) <b>30</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Anne Arundel</b> Md.		
10. CITY OR TOWN OF DEATH <b>Ft G.G. Meade, Md.</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kimbrough Army Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Ft Geo D Meade</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>7303-C Fournier St</b>	
14. FATHER'S NAME First Middle Last <b>JOSEF VAN HOUTTE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ESSER HELENE VAN HOUTTE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>James Webber(H) same as # 13 c &amp; e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic, carcinoma of cervix</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>171X</b>					
19a. DATE OF OPERATION <b>15 Nov 67</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hydronephrosis</b>	20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Was DOA</b> , <b>12 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Benatar</b>		DEGREE <b>CPT</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME <b>BENATAR, CPT, MC</b>		22e. ADDRESS <b>Kimbrough Army Hospital, Ft G. Meade, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>13 Feb 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>Samuel Turner</b>	ADDRESS <b>By N.A.D.</b>	25a. REC'D BY REGISTRAR <b>FEB 19 1968</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

05087

05087

UNITED STATES DEPARTMENT OF JUSTICE

TO: SAC, NEW YORK (100-100000) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <i>Curtis</i>		First		Middle <i>E.</i>		Last <i>Weekley</i>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>17</i> Year <i>68</i>		2b. HOUR <i>P</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>8-24-1931</i>		6. AGE (in years) <i>36</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>		2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>17</i> Year <i>68</i>	2d. HOUR <i>P</i>
7a. BIRTHPLACE (State or foreign country) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>					Md.
10. CITY OR TOWN OF DEATH <i>Selby-on-Bay</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A.A. GENERAL Hospt.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Petroleum</i>					
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before death if not) <i>Selby-on-Bay</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Selby-on-Bay</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>SELBY on BAY</i>			
14. FATHER'S NAME First <i>"UNK"</i> Middle <i>"UNK"</i> Last <i>"UNK"</i>		15. MOTHER'S MAIDEN NAME First <i>"UNK"</i> Middle <i>"UNK"</i> Last <i>"UNK"</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>VERNA L. WEEKLEY</i>		ADDRESS <i># 13 E.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>fall from ladder</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8199</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>2254</i>											
19a. DATE OF OPERATION <i>8-21-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Aut &amp; accident</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Aut &amp; accident</i>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M.</i> <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Aut &amp; accident</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <i>Highway</i>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or R.F.D. No. <i>RL 178</i>		City or Town <i>AA CO</i>		County <i>MD</i>		State <i>MD</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. L. L. Howard</i>		EXAMINER'S NAME (Type) <i>E. L. L. Howard</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIED</i>		23b. DATE <i>8-21-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		23d. LOCATION (City or town) <i>Annapolis</i>		(County) <i>MD</i>		(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>John M. Taylor &amp; Sons</i>		ADDRESS <i>Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Pinkie E. West					Month Day Year February 17, 1968		2:55 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	White		9-18-12		55 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland	United States				Anne Arundel			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie	North Arundel		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.	Anne Arundel		Glen Burnie				1134 Wynbrook Rd.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Louis Henderson				Helen Donsey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown	16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No	220-16-9169		Julius West		Glen Burnie Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Heart MI								
DUE TO, OR AS A CONSEQUENCE OF								
(b) rupture of Posterior Wall								
DUE TO, OR AS A CONSEQUENCE OF								
(c) of the Left Ventricle								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 11/19, 1967, to 2/17/68, 19, that (I) (we) lost saw the deceased alive on 2/17/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		J.B. Ramirez MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/18/68
22d. PHYSICIAN'S NAME (Type)		J.B. RAMIREZ MD		22e. ADDRESS		3927 ANNA COLIS RD Balt 27 325 Hospital Drive Glen Burnie		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE Feb. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial				Waters Memorial Cem.		Island Creek, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
A.A. Harkness & Son		Port Republic, Md		FEB 21 1968		Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Richard			Middle S.			Last WEST, Jr.			2a. DATE OF DEATH Month February 13 Day 1968 Year			2b. HOUR P. 8:50 M		
3. SEX M			4. RACE W			5. DATE OF BIRTH 6-30-1902			6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) TENN.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.								
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PROFESSOR			12b. KIND OF BUSINESS OR INDUSTRY TEACHING								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 213 N. GLEN AVE.					
14. FATHER'S NAME First RICHARD			Middle S.			Last WEST			15. MOTHER'S MAIDEN NAME First EDITH			Middle NORRIS			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT. MARIE MC WEST # 130						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 411.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unkown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>56</u> , to <u>Feb.</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>2/12/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>John Nederman MD</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/15/68								
22d. PHYSICIAN'S NAME (Type) JOHN NEDERMAN			22e. ADDRESS Forest Dr. Annapolis Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE 2-15-68			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Bhadenburg MD.								
24. FUNERAL DIRECTOR John M. Lyb... Annapolis Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE FEB 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

STATE OF NEW YORK

IN SENATE  
January 10, 1903  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 10, 1902  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02091

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film G398 2/28/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02078

1. DECEASED-NAME (Type or Print) First: EMMA Middle: L. Last: (Heckel) WHEELER			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 1968 Feb. 16			2b. HOUR A M				
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1 Apr. 1911	6. AGE (In years) 57 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 16 Year 1968			2d. HOUR A M	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Fort Meade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR INDUSTRY Mapel Farms	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STAT Maryland				13b. COUNTY A.A.CO.		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1590 Annapolis, Road
14. FATHER'S NAME First: UNKNOWN Middle: Last:			15. MOTHER'S MAIDEN NAME First: Carrie Middle: Fortenbough Last:							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If you give name or dates of service) 203-10-3381		17. INFORMANT Donald L. Wheeler-704 Broadview Blvd.			ADDRESS Glen Burnie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 514X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Fadden APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 522X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. Linhardt			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 2/16/68 M.M.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/21/68		23c. NAME OF CEMETERY OR CREMATORY Paxtang Cemetery			23d. LOCATION (City or Town) (County) (State) Paxtang. Pa.			
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md. R. P. Ware						25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE James		

0501

0501 01 01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Annie				WHIPPLE				February		8:25PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
7		C		12-8-1877		91 90 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
AA		USA				Anne Arundel				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		A.A. General Hosp									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER					
Maryland		Anne Arundel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		29 Hicks Ave					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First		Middle		Last		First		Middle		Last	
Unknown		Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes, no, or unknown				John Hicks		39 Bunch St		Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										2 mos	
IMMEDIATE CAUSE (a) 4120											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) 4120											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Annis T. Allen		2-8-68		Annis T. Allen							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Annis T. Allen											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
		2-12-68		Baltimore National		Baltimore				Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George W. TITTLE		BEL Air Md		DATE FEB 15 1968		Charles Jones					

27830

1972 06 01

1990-1991 3000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 5 & 6 Film G398 3/11/68 kk CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Ruth M. White						2a. DATE OF DEATH Month Day Year February 13, 1968			2b. HOUR 3:45 P.M.		
3. SEX F		4. RACE white		5. DATE OF BIRTH 9-13-89 1890			6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Somerset		13c. CITY OR TOWN Princess Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 1 Box 263		
14. FATHER'S NAME First Middle Last John H. Horner				15. MOTHER'S MAIDEN NAME First Middle Last Missouri Webster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Charles Whitelock; RFD #1 Princess Anne							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute, recurrent</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>urinary tract infection</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201 Fracture pubic bone on 12/7/67</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner) White <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work		21b. TIME OF INJURY HOUR (A.M. or P.M.) 12:38 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall on back Hall at her home		21d. INJURY OCCURRED at work <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) at her home		21f. LOCATION Street or R.F.D. No. City or Town County State Rt 1, Box 263 Princess Anne, Md	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7/67</u> , to <u>2/13/68</u> , that (I) (we) last saw the deceased alive on <u>3/9/67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul J. Utter, M.D.</u>						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/13/68</u>	
22d. PHYSICIAN'S NAME (Type) Paul J. Utter, M.D.						22e. ADDRESS 801 Chain Hwy SE, Glen Burnie					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2/16/68		23c. NAME OF CEMETERY OR CREMATORY Beechwood			23d. LOCATION (City or Town) (County) (State) Princess Anne; Somerset; Md.				
24. FUNERAL DIRECTOR <u>James L. Herman</u>						ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR DATE <u>FEB 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02080

02080

FOR COLLECTION

U.S. DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02094		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02081	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Ruth		Neats	WHITFIELD	February	28	68	4:00AM
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH July 24, 1914		6. AGE (In years last birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) N.D.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY OFFICE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Clarence Neats		15. MOTHER'S MAIDEN NAME First Middle Last Louise Rosevear		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 084050618	
17. INFORMANT Address KENNETH F. Whitfield - Alve		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with multiple metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1579</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18, 1968</u> to <u>2-28, 1968</u> , that (I) (we) last saw the deceased alive on <u>2-28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Ray M. Smith		22c. DATE SIGNED 2-28-68			
22d. PHYSICIAN'S NAME (Type) RAY M. SMITH		22e. ADDRESS SEVERNA PARK, MD.		22f. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE 3/7/68		23c. NAME OF CEMETERY OR CREMATORY Lee Crem.		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Robert S. Barrance		24a. ADDRESS Severna Park		25a. REC'D BY REGISTRAR DATE MAR 4 1968		25b. REGISTRAR'S SIGNATURE James J. Judge	

18950

UNITED STATES DEPARTMENT OF AGRICULTURE

05034

OFFICE OF THE SECRETARY



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 6 Film G398 3/6/68 ap

02062

<b>1. PLACE OF DEATH</b> a. COUNTY <u>7-11th Ave NE Md</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AD County</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>7-11th Ave Glen Burnie</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Santha Williams</u> First Middle Last <b>4. DATE OF DEATH</b> <u>Feb 25</u> 19 <u>68</u> Month Day Year				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 26 - 1880</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>Wesley Jackson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Oliver</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>160</u> <b>17. INFORMANT</b> <u>Barbara Armstrong</u> Address <u>Robert H. H. H.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Stroke &amp; Hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardiovascular disease</u> DUE TO (c) <u>Fracture of hip</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bed ridden by Fracture of hip</u> 4437						INTERVAL BETWEEN ONSET AND DEATH <u>1/2/68</u> <u>12/31/67</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>12/31/67</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>12/31/67</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>12/31, 1967</u> to <u>2/25, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/25, 1968</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Paul J. Chang</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Paul J. Chang, MD</u>				<b>22b. DATE SIGNED</b> <u>2/25/68</u> <b>22d. ADDRESS</b> <u>80, Crain Hwy SE, Glen Burnie</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2-28-68</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wheatley Cut</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Brooklyn Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Chung O. Wilson</u> ADDRESS <u>1000 Brantley Ave</u> <b>25a. REC'D BY REGISTRAR</b> <u>FEB 28 1968</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02080

CERTIFICATE OF DEATH

02080

02080



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304 REV. 1/68

02096		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02683									
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR					
ELBERT		H.		WILLING				Month 2 Day 13 Year 68		4:12 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		W		July 21, 1897				70 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Maryland		U.S.A.				Anne Arundel Md.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis, Md.		Annapolis Gen. Hosp.				Guard				Gibson Island					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Md.		A.A.		Pasadena, Md.				Chelsea Beach							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Alonza Willing								Mary (Taylor) Willing							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address									
no		217-08-0858		Mrs. Elbert H. Willing		Chelsea Beach Pasadena, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 7 YRS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42201															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 1968, 19, that (H) (we) last saw the deceased alive on 2-13-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
Arthur Lankford Jr. M.D.										2-13-68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS									
ARTHUR LANKFORD, JR., M. D.						PASADENA, MD 21122									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		2-16-68		Meadow Ridge Cemetery		Dorsey		Anne Arundel		Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
4101 Edmondson Avenue Witzke F. D., Balto., Md. 21229						DATE FEB 16 1968		Charles Judge							

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Male

Married

U.S.

Age 30

Address

City

State

Occupation

Education

Religion

Birth date

ARTHUR LAWRENCE, JR. M. C.

Handwritten signature

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02097

02084

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Md.</u>				c. LENGTH OF STAY IN 1b <u>18 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>North Shore Road - Rt 7 Box 100</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>W.</u> Last <u>Winnemore</u>				4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1968</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1888</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brockport, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brockport, N.Y.</u>	
13. FATHER'S NAME <u>Charles J. White</u>				14. MOTHER'S MARDEN NAME <u>Adaide Locke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-09-3350</u>		17. INFORMANT Address <u>Mrs. Esther Funch Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129 Coronary arteriosclerotic heart disease</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201 none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 8, 1968</u> to <u>February 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>February 15, 1968</u> , and that death occurred at <u>3 P.</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R.M. McLaughlin</u>				22b. DATE SIGNED <u>2/20/68</u>		22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>	
22d. ADDRESS <u>3108 Mountain Rd. Pasadena, Md.</u>		22e. ADDRESS <u>  </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-23-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW. Washington, D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02224

UNITED STATES OF AMERICA

02224

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02098

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

1. DECEASED-NAME (Type or Print) <b>Edwin</b>		First		Middle <b>F</b>		Last <b>Wolfe-Jr</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>2</b> Day <b>18</b> Year <b>1968</b>		2b. HOUR <b>P</b> M	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Jan 19, 1924</b>		6. AGE (in years last birthday) <b>44</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		2c. DATE PRONOUNCED DEAD Month <b>2</b> Day <b>18</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>P.A. Co</b> Md.					
10. CITY OR TOWN OF DEATH <b>glen Burnie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>D.O.A.-North ARUNDEL-</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>carpenter helper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>carpenter</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>13004-8th. Street</b>			
14. FATHER'S NAME <b>Edwin</b>		First		Middle <b>F</b>		Last <b>Wolfe</b>		15. MOTHER'S MAIDEN NAME <b>Nelen</b>		First <b>Canway</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>215-20-3959</b>		17. INFORMANT <b>MARGARET PAYNE BOWIE</b> ADDRESS <b>MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4299</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4344</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>E. Linhardt</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED <b>2/18/68</b>			
EXAMINER'S NAME (Type) <b>E. Linhardt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ADDRESS (Street, city, town, or county) <b>AAO</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waucho Chapel Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Odenton A.A. Co Md</b>					
24. FUNERAL DIRECTOR <b>De Witt Danachon</b>		ADDRESS <b>Laurel Md</b>		25a. REC'D BY REGISTRAR <b>FEB 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J...</b>					

05082

05082

RECEIVED - EXHIBIT 2 - EXHIBIT 10 - 10





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

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M 02093  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02686

1. DECEASED-NAME (Type or print) First Middle Last Eva J WOODEN		2a. DATE OF DEATH Month Day Year February 23, 1968.		2b. HOUR 8:30 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH 2-14-1885		6. AGE (In years and birthday) 83 YRS.
7a. BIRTHPLACE (State or foreign country) IND.		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.H. GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME
12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 7 DORCHESTER DR.				
14. FATHER'S NAME First Middle Last JOHN JOURDAN		15. MOTHER'S MAIDEN NAME First Middle Last CARRIE THUMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT Address Virginia Modell #13E.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis general</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>331X</u> Approximate interval between onset and death 48 Hours 15 YRS.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary Embolism, Hypertension</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>68</u> , to <u>2/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Edward S. Beck</u>		22c. DATE SIGNED 2/24/68		22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.
22e. ADDRESS Franklin St Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 3-1-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln
23d. LOCATION (City or Town) Bladensburg		23e. (County) MD.		(State)
24. FUNERAL DIRECTOR <u>John M. Taylor</u>		25. REG'D BY REGISTRAR FEB 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02100 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 5 per tele. con. with funeral director 2-23-68									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First		Middle		Last		
FRANCIS			L.		YAKIMICK				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2a. DATE KNOWN OF ESTI-DEATH MATED
male	white	March 25,		47 YRS.					<input checked="" type="checkbox"/> 2/16/ 1968
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U.S.				Anne Arundle Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Millersville			Dorsey Road			U.S. Army		Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		900 Langley Road
14. FATHER'S NAME			First		Middle		Last		
John			Yakimick		Sophie			Padrosky	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
yes			205-22-0569		Army records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		2/17/68	
DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 20, 1968		Arlington National		Arlington, Va.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry H. Witzke, 321 Columbia Pk.,			Ellicott City, Md.			FEB 23 1968		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02101		MARYLAND STATE DEPARTMENT OF HEALTH				02088	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
Items 13b,c, & Film G397 2/7/68 <b>CERTIFICATE OF DEATH</b>							
1. DECEASED-NAME (Type or print) <i>Catherine</i>			First Middle Last <i>Yell Dell</i>		2a. DATE OF DEATH Month <i>2<sup>nd</sup></i> Day <i>1</i> Year <i>68</i>		2b. HOUR <i>2:15 PM</i>
3. SEX <i>Female</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>11-3-1920</i>			6. AGE (In years last birthday) <i>47</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i> Md.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Plaza Martin Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laundry worker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>10 Johnson Place</i>	
14. FATHER'S NAME First Middle Last <i>William Wilson</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Hawkins</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>213-22-0612</i>			
16b. SOCIAL SECURITY NO. <i>213-22-0612</i>		17. INFORMANT <i>Sherman Gross</i> Address <i>10 Johnson Place, Unnapolis.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4120</i> IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Cardio-Vascular</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Epileptic</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 da.</i> <i>Unknown</i> <i>Unknown</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>443X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5-25</i> , 19 <i>65</i> , to <i>Jan 31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Jan 31</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard H. Hunt</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>						22e. ADDRESS <i>100 Cherry Lane, Glen Burnie, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/6/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR <i>William Reese, Jr. - Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>2</i> DATE <i>2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

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STATE OF TEXAS

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OFFICIAL RECORDS

OFFICIAL RECORDS